California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 22, NUMBER 1 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 JANUARY 2006

DENTI-CAL BENEFICIARY REIMBURSEMENTS

This is a reminder that in accordance with Welfare and Institutions Code Section 14019.3, a California Medi-Cal Dental Program (Denti-Cal) provider is required to reimburse a Denti-Cal beneficiary who paid for a medically necessary covered service rendered by the provider during any of the following three time periods: 1) the 90-day period prior to the month of application for Denti-Cal; 2) the period after an application is submitted but prior to the issuance of the beneficiary's Medi-Cal card; and 3) after issuance of the beneficiary's Medi-Cal card for excess co-payments (i.e., co-payments that should not have been charged to the beneficiary).

By law, a Denti-Cal provider must reimburse a beneficiary for a claim if the beneficiary provides proof of eligibility for the time period during which the medically necessary covered service was rendered (and for which the beneficiary paid). Evidence of the reimbursement paid by the provider to the beneficiary should be submitted to the Denti-Cal program as a claim with the appropriate documentation to indicate that Denti-Cal eligibility was recently disclosed. The Department of Health Services (Department) will allow the provider a timeliness override in order to bill Denti-Cal for the repaid services. If the provider does not reimburse the beneficiary, the beneficiary may contact the Department, inform the Department of the provider's refusal to reimburse, and then submit a request for reimbursement directly to the Department. In this case, the Department will contact the provider and request that the provider reimburse the beneficiary. Should the provider refuse to cooperate, the Department will reimburse the beneficiary for valid claims and recoup the payment from the provider. Additional sanctions may be imposed on the provider such as those set forth in Welfare and Institutions Code Section 14019.3. This statute is provided below for your information:

WELFARE AND INSTITUTIONS CODE 14019.3

14019.3. (a) A beneficiary or any person on behalf of a beneficiary who has paid for medically necessary health care services, otherwise covered by the Medi-Cal program, received by the beneficiary shall be entitled to a return from a provider or directly from the department of any part of the payment that meets all of the following:

(1) Was rendered during the 90-day period prior to application for his or her Medi-Cal card, or after application for but prior to the issuance of his or her Medi-Cal card, for which the card authorizes payment under Section 14018 or 14019, or was charged to the beneficiary as excess co-payment during the period after issuance of his or her Medi-Cal card.

(2) Is not payable by a third party under contractual or other legal entitlement.

(3) Was not used to satisfy his or her paid or obligated liability for health care services or to establish eligibility.

(b) To the extent permitted by federal law, whether or not a facility actually evicts a beneficiary, a beneficiary who may validly be evicted pursuant to Section 1439.7 of the Health and Safety Code, and who has received and paid for health care services otherwise covered by the Medi-Cal program shall not be entitled to the return from a provider of any part of the payment for which service was rendered during any period prior to the date upon which knowledge is acquired by a provider of the application of a beneficiary for Medi-Cal or the date of application for Medi-Cal, whichever is later.

(c) Upon presentation of the Medi-Cal card or other proof of eligibility, a provider shall submit a Medi-Cal claim for reimbursement, subject to the rules and regulations of the Medi-Cal program.

(d) Notwithstanding subdivision (c), payment received from the state in accordance with Medi-Cal fee structures shall constitute payment in full, except that a provider, after making a full refund to the department of any Medi-Cal payments received for services, may recover all provider fees to the extent that any other contractual entitlement, including, but not limited to, a private group or indemnification insurance program, is obligated to pay the charges for the care provided a beneficiary.

(e) A provider shall return any and all payments made by a beneficiary, or any person on behalf of a beneficiary, other than a third party obligated to pay charges by reason of a beneficiary's other contractual or legal entitlement for Medi-Cal program covered services upon receipt of Medi-Cal payment.

a. To the extent permitted by federal law, the department shall waive overpayments made to a pharmacy provider that would otherwise be reimbursable to the department for prescription drugs returned to a pharmacy provider from a nursing facility upon discontinuation of the drug therapy or death of a beneficiary.

b. The department shall ensure payment to a beneficiary from a provider. A provider shall be notified in writing by the department when a beneficiary has submitted a claim to the department for reimbursement of services provided during the periods specified in paragraph (1) of subdivision (a). If a provider is not currently enrolled in the Medi-Cal program, the department shall assist in that enrollment. Enrollment in the Medi-Cal program may be made retroactive to the date the service was rendered.

c. If a provider fails or refuses to reimburse a beneficiary for services provided during the periods specified in paragraph (1) of subdivision (a), within 90 days of receipt by the department of a written request by a beneficiary or a representative of a beneficiary, the department may take enforcement action that may include, but shall not be limited to, any or all of the following:

    1) Withholding of future provider payments.

    2) Suspension of a provider from participation in the Medi-Cal program.

    3) Recoupment of funds from a provider.

i) If a provider fails or refuses to reimburse a beneficiary within 90 days after receipt by the department of a written request from a beneficiary or a

representative of a beneficiary, the department shall directly reimburse a beneficiary for medically necessary health care expenses incurred during the periods specified in paragraph (1) of subdivision (a). The department shall reimburse a beneficiary only to the extent that federal financial participation is available and only when the claim meets all of the following criteria:

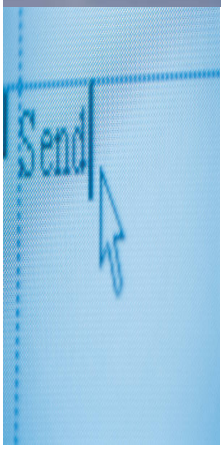
1) The service was a covered benefit under the Medi-Cal program.
2) The provider was an enrolled Medi-Cal provider at the time the service was rendered.
3) The service was ordered by a health care provider, within the scope of his or her practice.
4) The beneficiary is eligible for reimbursement, as specified in subdivision (a).
5) The reimbursement shall be the amount paid by the beneficiary, not to exceed the rate established for that service under the Medi-Cal program.

j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of the Government Code, this section may be implemented with a provider bulletin or similar notification, without any further regulatory action.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 22, NUMBER 2 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 JANUARY 2006



Learn About Electronic Claims Submission!

ELECTRONIC DATA INTERCHANGE SEMINARS

1st Quarter Schedule

Electronic Data Interchange (EDI) seminars provide a general introduction to electronic claims submission and helpful tips for offices currently submitting claims electronically. These *FREE* presentations cover the advantages of EDI, how electronic claims are processed, how to best utilize electronic reports and other practical hints.

First Quarter 2006 Seminar Schedule

DATE:	CITY:	TIME:	LOCATION:
March 10	*San Jose*	*1:15 pm to 4:15 pm*	***San Jose Convention Center*** **408 Almaden Boulevard** **San Jose, CA 95110** **(408) 277-5277**

Seating is limited.
For reservations, please call Denti-Cal toll-free at
(800) 423-0507.

Continuing education credits from the Academy of General Dentistry are available.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 22, NUMBER 3 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 JANUARY 2006

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

National Provider Identifier (NPI) Update

Denti-Cal is currently assessing its present systems to comply with the HIPAA regulations for implementing the NPI. Denti-Cal providers, dental plans, and clearinghouses must begin using/accepting the NPI on all HIPAA electronic covered transactions beginning May 23, 2007.

Providers must continue utilizing their existing Denti-Cal provider numbers until further notice.

Providers may apply for an NPI by:

- Visiting the Web site at http://nppes.cms.hhs.gov, or
- Mailing a completed paper application to the address found at the above Web site, or
- Calling (800) 465-3203 or (800) 692-2326 (TTY).

For more general information about the NPI, please visit the Web site for the Centers for Medicare & Medicaid Services (CMS) at http://www.cms.hhs.gov/EmployerIdentifierStand.

If there are any questions, please call Denti-Cal, toll-free, at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 22, NUMBER 4 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 FEBRUARY 2006

CHANGES TO RENDERING PROVIDER ENROLLMENT PROCESS

Effective immediately, rendering providers within provider groups no longer need to re-enroll for every group and location where they practice. Previously, providers were required to submit an application package for every provider group or location where they intended to practice. Due to a change in *California Code of Regulations* (CCR), Title 22, §51000.31(b), rendering providers now need to apply to the Medi-Cal Dental Program (Denti-Cal) only once.

Rendering providers in good standing may join existing provider groups or practice at other locations without having to submit a new application package each time.

To initially enroll as a rendering provider, the applicant needs to submit a complete application package. All required forms can be obtained by contacting the Telephone Service Center at (800) 423-0507.

In order for Denti-Cal to maintain an accurate Beneficiary Referral Listing, we request that you continue to notify Denti-Cal when associating or disassociating a specialist to your practice.

If you have any questions, please call Denti-Cal toll-free at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 22, NUMBER 5 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 FEBRUARY 2006

Updated Information

Denti-Cal Ends Provider Payment Reductions

Effective for dates of service on or after March 4, 2006, Denti-Cal will end the five percent (5%) payment reduction for program services, in accordance with Senate Bill (SB) 912, (Statues of 2006, Chapter 8). The five percent (5%) reduction was implemented January 1, 2006, in accordance with *Welfare and Institutions Code*, §14105.19.

The following were exempt from the payment reduction and will see no change in Denti-Cal payments:

- Breast and Cervical Cancer Early Detection Program (BCCEDP)
- Breast Cancer Control Program
- California Children's Services (CCS) Program (both Medi-Cal and non Medi-Cal)
- Child Health and Disability Prevention (CHDP) Program (both Medi-Cal and non Medi-Cal)
- Genetically Handicapped Persons Program (GHPP)

Because the five percent (5%) reduction was previously implemented for payments to managed care plans, ending of the payment reduction described in this notice does not apply to managed care plans.

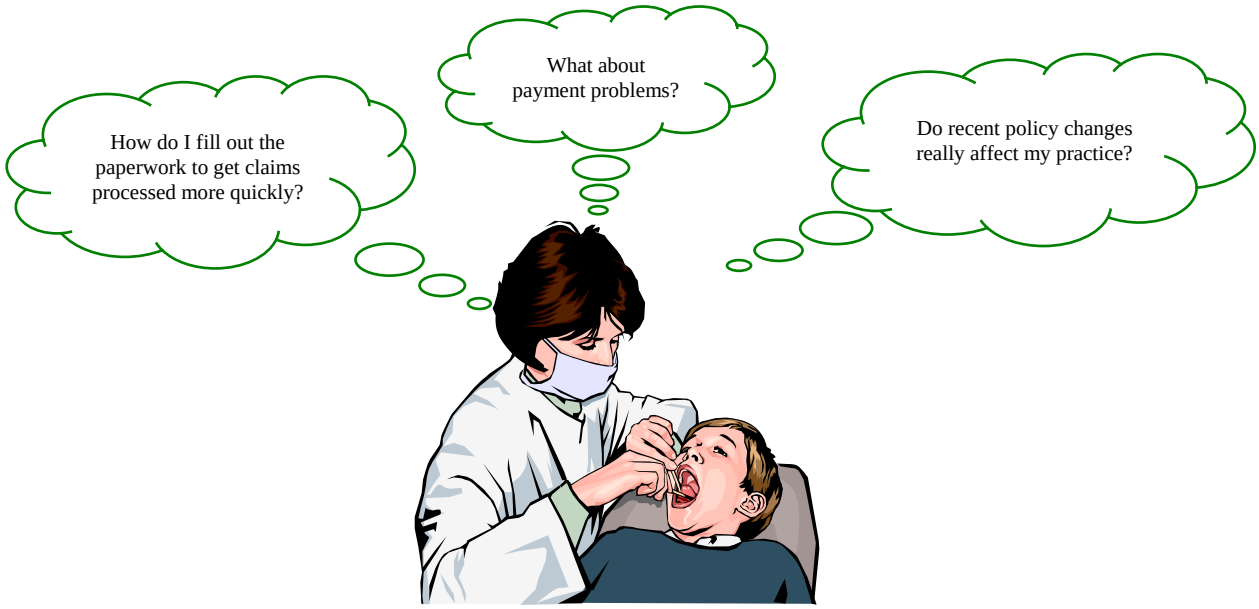
For answers to questions, please call Denti-Cal toll-free at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 22, NUMBER 6 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 FEBRUARY 2006

SEMINAR SCHEDULE FOR SECOND QUARTER, 2006



Basic Seminars

- Introduction to California Medi-Cal Dental Program
- Enrollment and Eligibility
- Proper Billing Procedures
- The San Bernardino seminar has been expanded half an hour to include an overview of the Electronic Data Interchange (EDI)

Workshops

- Enrollment and Eligibility
- Criteria and Current Changes
- Hands-On Forms Completion
- HIPAA Informational Updates

Advanced Seminars

- Criteria Presented *by* a Dentist *for* Dentists and Staff
- View Actual Treatment Slides

ABOUT THE SEMINARS AND WORKSHOPS

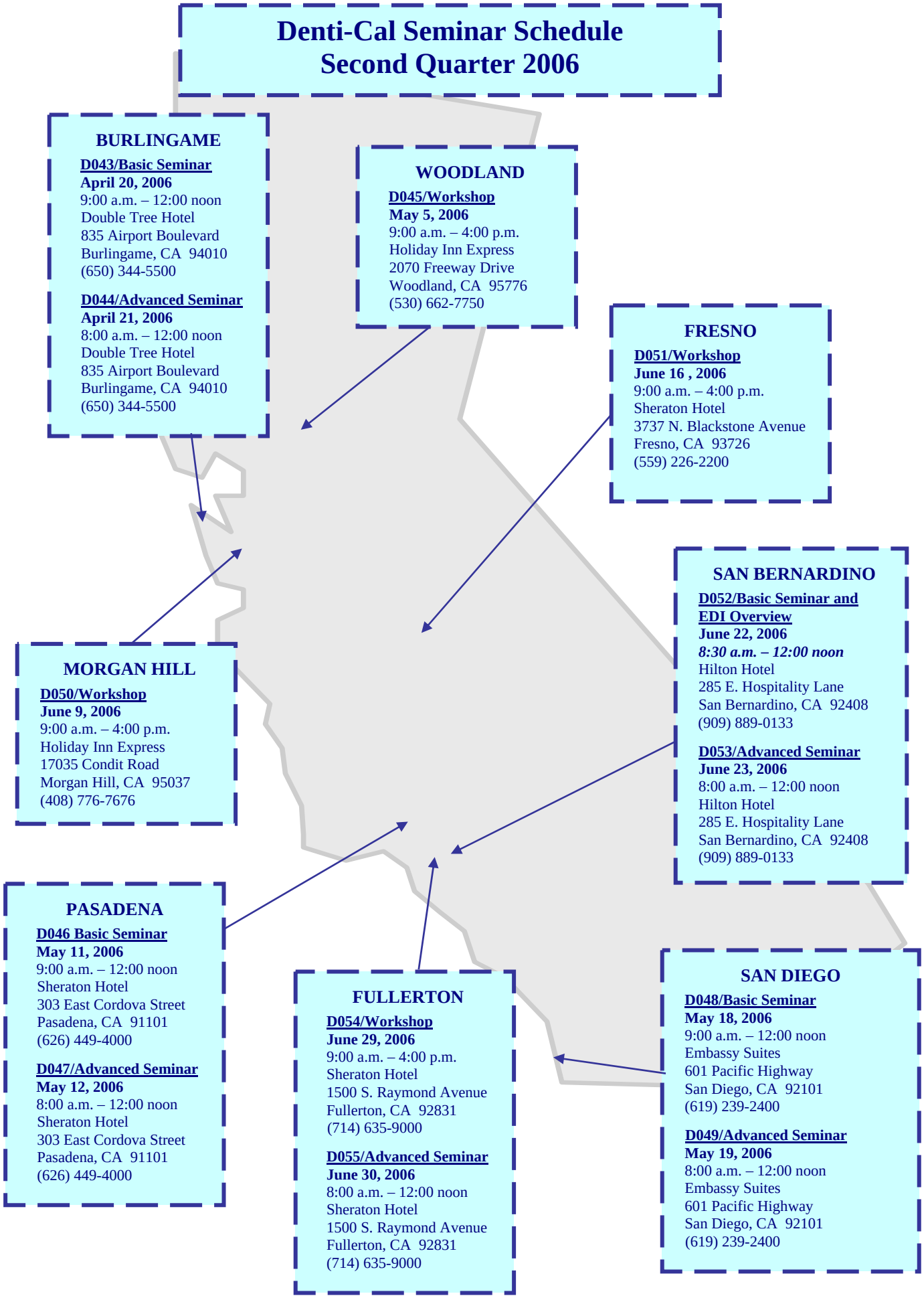
- Seminars and workshops are offered *free of charge*.
- Sessions begin *on time*, so arrive early.
- Bring your updated *Denti-Cal Provider Manual* to get the most from the training.
- Audio/video recording is not allowed.
- Billing information is subject to change.
- Reservations ensure that a space is available for you! Likewise, please let us know if you are unable to attend.
- Continuing education credits are available:

Basic Seminars	3 CE credits
Advanced Seminars	4 CE credits
Workshops	6 CE credits

- Some facilities may charge for parking.
- The use of cell phones during the seminar is strongly discouraged. If you must be available for calls, please be courteous and set the ringer on vibrate.

For additional information, questions and to register, please phone Denti-Cal toll free at 800/423-0507.

Denti-Cal Seminar Schedule
Second Quarter 2006



BURLINGAME

D043/Basic Seminar
April 20, 2006
9:00 a.m. – 12:00 noon
Double Tree Hotel
835 Airport Boulevard
Burlingame, CA 94010
(650) 344-5500

D044/Advanced Seminar
April 21, 2006
8:00 a.m. – 12:00 noon
Double Tree Hotel
835 Airport Boulevard
Burlingame, CA 94010
(650) 344-5500

WOODLAND

D045/Workshop
May 5, 2006
9:00 a.m. – 4:00 p.m.
Holiday Inn Express
2070 Freeway Drive
Woodland, CA 95776
(530) 662-7750

FRESNO

D051/Workshop
June 16 , 2006
9:00 a.m. – 4:00 p.m.
Sheraton Hotel
3737 N. Blackstone Avenue
Fresno, CA 93726
(559) 226-2200

SAN BERNARDINO

D052/Basic Seminar and EDI Overview
June 22, 2006
8:30 a.m. – 12:00 noon
Hilton Hotel
285 E. Hospitality Lane
San Bernardino, CA 92408
(909) 889-0133

D053/Advanced Seminar
June 23, 2006
8:00 a.m. – 12:00 noon
Hilton Hotel
285 E. Hospitality Lane
San Bernardino, CA 92408
(909) 889-0133

MORGAN HILL

D050/Workshop
June 9, 2006
9:00 a.m. – 4:00 p.m.
Holiday Inn Express
17035 Condit Road
Morgan Hill, CA 95037
(408) 776-7676

PASADENA

D046 Basic Seminar
May 11, 2006
9:00 a.m. – 12:00 noon
Sheraton Hotel
303 East Cordova Street
Pasadena, CA 91101
(626) 449-4000

D047/Advanced Seminar
May 12, 2006
8:00 a.m. – 12:00 noon
Sheraton Hotel
303 East Cordova Street
Pasadena, CA 91101
(626) 449-4000

FULLERTON

D054/Workshop
June 29, 2006
9:00 a.m. – 4:00 p.m.
Sheraton Hotel
1500 S. Raymond Avenue
Fullerton, CA 92831
(714) 635-9000

D055/Advanced Seminar
June 30, 2006
8:00 a.m. – 12:00 noon
Sheraton Hotel
1500 S. Raymond Avenue
Fullerton, CA 92831
(714) 635-9000

SAN DIEGO

D048/Basic Seminar
May 18, 2006
9:00 a.m. – 12:00 noon
Embassy Suites
601 Pacific Highway
San Diego, CA 92101
(619) 239-2400

D049/Advanced Seminar
May 19, 2006
8:00 a.m. – 12:00 noon
Embassy Suites
601 Pacific Highway
San Diego, CA 92101
(619) 239-2400

DENTI-CAL PROVIDER TRAINING SEMINAR RESERVATION FORM

TYPE OF SEMINAR:

☐ Basic Seminar
(Seminar Code Number:_____)

☐ Workshop
(Seminar Code Number:_____)

☐ Advanced Seminar
(Seminar Code Number:_____)

Seating for all seminars is limited, so reserve your place today by returning this reservation form in the enclosed envelope to Denti-Cal. Be sure to include the seminar code number and indicate the names of staff who will be attending. Denti-Cal is unable to confirm your reservation by mail, so be sure to note the date and time on your calendar. ***To help us keep administrative costs down and continue to offer you free educational seminars, we request that you notify Denti-Cal toll-free at (800) 423-0507 in the event you need to cancel your reservation.***

PLEASE TYPE OR PRINT CLEARLY

Yes, I/my office staff wish to attend the Denti-Cal provider training seminar(s) indicated above. The name(s) of the person(s) attending are:

1._____ 4._____

2._____ 5._____

3._____ 6._____

In the area below, please type or print the dentist's name and office address:

_____ Provider No.:_____

_____

_____ Phone No.:_____

_____

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 22, NUMBER 7 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 FEBRUARY 2006

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

National Provider Identifier (NPI) Update

Denti-Cal is currently assessing its present systems to comply with the HIPAA regulations for implementing the NPI. Denti-Cal providers, dental plans, and clearinghouses must begin using/accepting the NPI on all HIPAA electronic covered transactions beginning May 23, 2007.

Providers must continue utilizing their existing Denti-Cal provider numbers until further notice.

Providers may apply for an NPI by:

- Visiting the Web site at http://nppes.cms.hhs.gov, or
- Mailing a completed paper application to the address found at the above Web site, or
- Calling (800) 465-3203 or (800) 692-2326 (TTY).

For more general information about the NPI, please visit the Web site for the Centers for Medicare & Medicaid Services (CMS) at http://www.cms.hhs.gov/NationalProvIdentStand.

If there are any questions, please call Denti-Cal, toll-free, at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 22, NUMBER 8 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 MARCH 2006

NEW VERSIONS OF THE PROVIDER APPLICATION AND DISCLOSURE FORMS

All provider application and disclosure forms have been changed to comply with the disclosure requirements of California Code of Regulations, Title 22, Sections 51000.30, 51000.31, 51000.35, and 51000.40. Effective April 17, 2006, the Denti-Cal Program will begin utilizing the same applications used by providers participating in the Medi-Cal Program.

Welfare and Institutions Code (W&I Code) Section 14043.15(a) grants the California Department of Health Services (Department) the authority to adopt regulations for the certification of each applicant and each provider in the Medi-Cal Program.

W&I Code Section 14043.15(b)(1) requires that applicants who are natural persons licensed or certificated under the Business and Professions Code or the Osteopathic or Chiropractic Initiative Acts to provide health care services, or who are professional corporations under subdivision (b) of Section 13401 of the Corporations Code, must enroll in the Medi-Cal Program as either individual providers or as rendering providers in a provider group. This is true even if the person or the professional corporation meets the requirements to qualify as exempt from clinic licensure under subdivision (a) or (m) of Section 1206 of the Health and Safety Code.

W&I Code Section 14043.26(a)(1) requires that an applicant not currently enrolled in the Medi-Cal Program, or a provider applying for continuing enrollment, upon written notification from the Department that enrollment for continued participation of all providers in a specific provider of service category or subgroup of that category to which the provider belongs will occur, or a provider not currently enrolled at a location where the provider intends to provide services, goods, supplies, or merchandise to a Medi-Cal beneficiary, shall submit a complete application package for enrollment, continued enrollment, or enrollment at a new location or a change in location.

Based upon the authority granted to the Director of the Department in W&I Code Section 14043.75(b), the Director hereby designates the following revised applications and disclosure statements that shall be completed by an applicant or provider when required by the California Code of Regulations (CCR), Title 22, Sections 51000.30, 51000.31, 51000.32, 51000.35, and/or 51000.40. This designation is a regulation implementing W&I Code Section 14043.15 and 14043.26 and has the full force and effect of law. This designation is effective for all application and disclosure packages received on or after April 17, 2006. Those applications mailed prior to April 17, 2006 will continue to be processed until June 15, 2006, under the rules and regulations in effect at the time the application and disclosure packages were received.

The applicant or provider, when required pursuant to CCR, Title 22, Sections 51000.30, 51000.31, 51000.32, 51000.35, and/or 51000.40, shall complete and submit, as applicable, the following applications and forms:

- ✓ Medi-Cal Provider Group Application - DHS 6203 (Rev. 1/06)
- ✓ Medi-Cal Provider Application - DHS 6204 (Rev. 1/06)

- ✓ Medi-Cal Disclosure Statement - DHS 6207 (Rev. 1/06)
- ✓ Medi-Cal Provider Agreement - DHS 6208 (Rev. 1/06)
- ✓ Medi-Cal Supplemental Changes - DHS 6209 (Rev. 1/06)
- ✓ Medi-Cal Rendering Provider Application/Disclosure Statement/Agreement for Physician/Allied/Dental Providers - DHS 6216 (Rev. 1/06)
- ✓ Successor Liability with Joint and Several Liability Agreement - DHS 6217 (Rev. 1/06)

Providers have two options to receive the new enrollment application forms:

1) Effective April 17, 2006, download the applications from the California Medi-Cal Web site at http://www.medi-cal.ca.gov. Go to Provider Enrollment; Application Forms. Applications shall only be printed on one side, not duplexed (i.e., double-sided).
2) Contact the Denti-Cal Telephone Service Center at (800) 423-0507 and request that an application package be mailed.

If you have any further questions regarding the new enrollment applications, please call Denti-Cal at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 22, NUMBER 9 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 MARCH 2006

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

National Provider Identifier (NPI) Update

Denti-Cal is currently assessing its present systems to comply with the HIPAA regulations for implementing the NPI. Denti-Cal providers, dental plans, and clearinghouses must begin using/accepting the NPI on all HIPAA electronic covered transactions beginning May 23, 2007.

Providers must continue utilizing their existing Denti-Cal provider numbers until further notice.

Providers may apply for an NPI by:

- ✓ Visiting the Web site at http://nppes.cms.hhs.gov, or
- ✓ Mailing a completed paper application to the address found at the above Web site, or
- ✓ Calling (800) 465-3203 or (800) 692-2326 (TTY).

For more general information about the NPI, please visit the Web site for the Centers for Medicare & Medicaid Services (CMS) at http://www.cms.hhs.gov/NationalProvIdentStand.

Current Dental Terminology (CDT)

CDT has been delayed pending the final approval of Manual of Criteria (MOC) regulations, which is a State legislative process. As a result, CDT-4 training sessions and the distribution of the MOC and Schedule of Maximum Allowances (SMA) related to the implementation of CDT-4 codes are also postponed.

CDT codes are not accepted by Denti-Cal at this time. Any claim service line (CSL) submitted with a CDT procedure code, an invalid procedure code, or a blank procedure code field, will be denied.

VISIT DENTI-CAL AND ELECTRONIC DATA INTERCHANGE (EDI) BOOTHS AT ANAHEIM CALIFORNIA DENTAL ASSOCIATION (CDA) SCIENTIFIC SESSION

Be sure to visit the Denti-Cal booths at the CDA Scientific Session in Anaheim, beginning Friday, April 28, 2006 through Sunday, April 30, 2006. Representatives from Denti-Cal will be on hand in Booths 741 and 743, Hall B, of the Anaheim Convention Center to provide information and answer questions.

REMINDER: UPCOMING DENTI-CAL SEMINARS

These seminars will be presented during the month of April:

April 20, 2006	D043/Basic Seminar	Burlingame
April 21, 2006	D044/Advanced Seminar	Burlingame

If in your area, please consider attending, then telephone Denti-Cal toll-free at (800) 423-0507 to make a reservation. Denti-Cal Bulletin Volume 22, Number 6 contains specifics about these and other seminars.

ELECTRONIC DATA INTERCHANGE (EDI) ENROLLMENT INFORMATION

For an EDI Enrollment Packet, please contact Provider Services toll-free at (800) 423-0507. For an EDI How-To Guide or for other information on submitting Denti-Cal claims and Treatment Authorization Requests (TARs) electronically, please call (916) 853-7373 and ask for EDI Support.

CORRECTION

A typographical error was made in Volume 22, Number 5: Denti-Cal Ends Provider Payment Reductions. The first sentence *should* read:

> Effective for dates of service on or after March 4, 2006, Denti-Cal will end the five percent (5%) payment reduction for program services, in accordance with Senate Bill (SB) 912, (Statutes of 2006, Chapter 8).

NO CLAIM ACTIVITY FOR 12 MONTHS

Providers who have had no claim activity (submitting no claims or requesting reimbursement) in a 12-month period shall be deactivated per Welfare and Institutions Code Section 14043.62 which reads as follows:

> The department shall deactivate, immediately and without prior notice, the provider numbers used by a provider to obtain reimbursement from the Medi-Cal program when warrants or documents mailed to a provider's mailing address or its pay to address, if any, or its service or business address, are returned by the United States Postal Service as not deliverable or when a provider has not submitted a claim for reimbursement from the Medi-Cal program for one year. Prior to taking this action the department shall use due diligence in attempting to contact the provider at its last known telephone number and ascertain if the return by the United States Postal Service is by mistake or shall use due diligence in attempting to contact the provider by telephone or in writing to ascertain whether the provider wishes to continue to participate in the Medi-Cal program. If deactivation pursuant to this section occurs, the provider shall meet the requirements for reapplication as specified in this article or the regulations adopted thereunder.

If you have not treated any Medi-Cal patients within a 12-month period your Medi-Cal Dental Program provider number will be deactivated. If you wish to remain an active provider in the Medi-Cal Dental Program, complete the form below and mail to: Post Office Box 15609, Sacramento, CA 95852-0609. If the form is not received by Denti-Cal prior to the end of the 12-month period, your provider number will be deactivated. If your provider number is deactivated, you must reapply for enrollment in the Medi-Cal Dental Program. To request an enrollment package contact Denti-Cal toll free at (800) 423-0507.

Yes, I wish to remain a provider in the California Medi-Cal Dental Program because _____

_____.

Check the boxes that apply to your practice:

- ☐ AHK (Alameda Healthy Kids)
- ☐ CCS (California Children's Services)
- ☐ DMC (Dental Managed Care) Plan Name: _____
- ☐ FQHC/RHC (Federally Qualified Health Clinic/Rural Health Clinic)
- ☐ GHPP (Genetically Handicapped Persons Program)
- ☐ GMC (Geographic Managed Care) Plan Name: _____
- ☐ HFP (Healthy Families Program)

_____	_____	_____
Provider Name	Provider Number	Provider Signature

If there are any questions, please contact Denti-Cal at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 22, NUMBER 10 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 APRIL 2006

$1,800 LIMIT PER CALENDAR YEAR FOR BENEFICIARY SERVICES (DENTAL CAP)

The California Department of Health Services has implemented changes in covered benefits. Section 14080 of the Welfare and Institutions Code stipulates that from January 1, 2006 through January 1, 2009, non-exempt dental services to beneficiaries 21 years of age and above will be capped at $1,800 per beneficiary for each calendar year.

Providers are reminded to check the beneficiary cap status prior to rendering services to determine the current remaining balance. This information can be obtained by calling Denti-Cal toll-free at (800) 423-0507.

To help reduce the possibility that procedures performed will not be fully paid because the dental cap has been reached, providers should

- ✓ verify the beneficiary cap.
- ✓ discuss with beneficiary any other treatment recently received from another provider.
- ✓ quickly submit claims for procedures not requiring prior authorization.
- ✓ upon receipt of a Notice of Authorization (NOA), promptly perform services and submit requests for payment.

Debits toward the cap are based upon the order in which claims/NOAs are processed. Authorization does not guarantee payment. Non-exempt services will be paid in the order they are received and processed until the annual cap is reached for a calendar year.

Adjudication Reason Code 500, created to assist in the processing of claims, reads as follows:

500 Payment for this service reflects the maximum allowable amount as beneficiary services dental cap has been met.

For additional information, please consult the three previous bulletins detailing this subject: Volume 21, Numbers 34, 35, and 36 (the list of exempt procedure codes is found in Volume 21, Number 36). If there are questions regarding any of the above, please call Denti-Cal at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 22, NUMBER 11 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 APRIL 2006

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

National Provider Identifier (NPI) Update

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Providers must continue utilizing their existing Denti-Cal provider numbers until further notice.

Providers may apply for an NPI by:

- ✓ Visiting the Web site at http://nppes.cms.hhs.gov, or
- ✓ Mailing a completed paper application to the address found at the above Web site, or
- ✓ Calling (800) 465-3203 or (800) 692-2326 (TTY).

For more general information about the NPI, please visit the Web site for the Centers for Medicare & Medicaid Services (CMS) at http://www.cms.hhs.gov/NationalProvIdentStand.

Current Dental Terminology (CDT)

CDT has been delayed pending the final approval of Manual of Criteria (MOC) regulations, which is a State legislative process. As a result, CDT-4 training sessions and the distribution of the MOC and Schedule of Maximum Allowances (SMA) related to the implementation of CDT-4 codes are also postponed.

CDT codes are not accepted by Denti-Cal at this time. Any claim service line (CSL) submitted with a CDT procedure code, an invalid procedure code, or a blank procedure code field, will be denied.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 22, NUMBER 12 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 MAY 2006

CHILDREN'S TREATMENT PROGRAM (CTP) FIVE PERCENT (5%) REIMBURSEMENT

Effective March 4, 2006, Denti-Cal ended the five percent (5%) payment reduction for the Children's Treatment Program (CTP), as a result of the passage of Senate Bill (SB) 912, (Statues of 2006, Chapter 8). The five percent (5%) reduction was implemented August 1, 2003, in accordance with *Welfare and Institutions Code*, §16934.5(b)(c).

Once system changes have been made, retroactive reimbursement will be made for dates of service back to March 4, 2006.

Attached please find the new Schedule of Maximum Allowances (SMA).

If there are any questions, please contact Denti-Cal toll-free at (800) 423-0507.

CHDP/CTP FEE SCHEDULE

Effective March 4, 2006

1. Fees payable to providers by Denti-Cal for covered services shall be the LESSER of:
   a. provider's billed amount
   b. the maximum allowance set forth in the schedule below
2. Refer to your Denti-Cal Provider Manual for specific procedure instructions and program limitations.

Procedure Number	Procedure	Maximum Allowance
Visits - Diagnostic (Procedures 010-099)		
010	Complete examination, initial episode of treatment only	25.00
015	Examination periodic (annual)	15.00
020	Office visit during regular office hours, for treatment and/or observation of teeth or supporting structures	20.00
030	Professional visit after regular office hours or to bedside	35.00
035	Hospital care	50.00
040	Specialist consultation	35.00
045	Pit and fissure dental sealants for permanent first molars, beneficiaries to age twenty-one (21)	22.00
046	Pit and fissure dental sealants for permanent second molars, to age twenty-one (21)	22.00
049	Prophylaxis, beneficiaries through age 12	30.00
050	Prophylaxis, beneficiaries age 13 years of age and over	40.00
061	Prophylaxis, including topical application of fluoride, beneficiaries age 5 and under	35.00
062	Prophylaxis, including topical application of fluoride, beneficiaries age 6 through 17 years of age	40.00
080	Emergency treatment, palliative	45.00
Radiographs and Photographs (Procedures 110-125)		
110	Intraoral periapical, single, first radiograph	10.00
111	Intraoral periapical, each additional radiograph	3.00
112	Intraoral, complete series	45.00
113	Intraoral, occlusal radiograph	10.00
114	Extraoral, single, head or lateral jaw	22.00
115	Extraoral, each additional head or lateral jaw	5.00
116	Bitewings, two radiographs	10.00
117	Bitewings, four radiographs	18.00
118	Bitewing, anterior, one radiograph	5.00
119	Photograph or slide, first	7.00
120	Photograph or slide, each additional (maximum five)	3.00
125	Panographic-film, single radiograph	25.00
Biopsy and Pathology Reports (Procedures 150-199)		
150	Biopsy of oral tissue	100.00
160	Gross and microscopic histopathological examination	50.00

Procedure Number	Procedure	Maximum Allowance
Oral Surgery (200-299)		
200	Removal of erupted tooth, uncomplicated, first tooth	45.00
201	Removal of erupted tooth (teeth), uncomplicated, each additional tooth	38.00
202	Removal of erupted tooth, surgical	85.00
203	Removal of root or root tip completely covered by bone	100.00
204	Removal of root or root tip not completely covered by bone	40.00
220	Postoperative visit, complications e.g., osteitis	15.00
230	Removal of impacted tooth, soft tissue	100.00
231	Removal of impacted tooth, partial bony	135.00
232	Removal of impacted tooth, complete bony	165.00
250	Alveoloplasty per quadrant, edentulous	100.00
252	Alveoloplasty per quadrant, in conjunction with extractions	50.00
255	Vestibuloplasty, submucosal resection (not to include grafts)	400.00
256	Alveoloplasty with ridge extension, secondary epithelialization (per arch)	200.00
257	Removal of palatal exostosis (torus)	200.00
258	Removal of mandibular exostosis (torus) per quadrant	100.00
259	Excision of hyperplastic tissue (per arch)	100.00
260	Incision and drainage of abscess, intraoral	50.00
261	Incision and drainage of abscess, extraoral	75.00
262	Excision pericoronal gingiva, operculectomy	50.00
263	Sialolithotomy, intraoral	235.00
264	Sialolithotomy, extraoral	300.00
265	Closure of salivary fistula	120.00
266	Dilation of salivary duct	120.00
267	Reduction of tuberosity, unilateral	75.00
269	Excision of benign tumor, up to 1.25 cm	100.00
270	Excision of benign tumor, larger than 1.25 cm	250.00
271	Excision of malignant tumor	325.00
273	Reimplantation and/or stabilization of accidentally evulsed or displaced permanent tooth and/or alveolus	175.00
275	Transplantation of tooth or tooth bud	1000.00
276	Removal of foreign body from bone (independent procedure)	130.00
277	Radical resection of bone for tumor with bone graft	1200.00
278	Maxillary sinusotomy for removal of tooth fraction or foreign body	380.00
279	Oral antral fistula closure	300.00
280	Excision of cyst up to 1.25 cm	100.00
281	Excision of cyst over 1.25 cm	200.00
282	Sequestrectomy	100.00
285	Condylectomy of mandible, unilateral	1000.00
289	Menisectomy of temporomandibular joint, unilateral	1000.00
290	Excision of foreign body, soft tissue	60.00
291	Frenectomy, or frenotomy, separate procedure	100.00
292	Suture of soft tissue wound or injury	50.00
294	Injection of sclerosing agent into temporomandibular joint	75.00
295	Injection of trigeminal nerve branches for destruction	200.00
296	Surgical exposure of impacted or unerupted tooth to aid eruption, soft tissues	100.00

Procedure Number	Procedure	Maximum Allowance
297	Surgical exposure of impacted or unerupted tooth to aid eruption, partial bony	135.00
298	Surgical exposure of impacted or unerupted tooth to aid eruption, complete bony	135.00
299	Unlisted surgical service or procedure	By Report
Drugs and Anesthesia (300-400)		
300	Therapeutic drug injection	15.00
301	Conscious sedation, relative analgesia (nitrous oxide), per visit	25.00
400	General anesthesia	100.00
Periodontics (450-499)		
451	Emergency treatment (periodontal abscess, acute periodontitis, etc.)	55.00
452	Subgingival curettage and root planing, per full mouth treatment	118.00
	(residents of SNF or ICF)	200.00
453	Occlusal adjustment (limited) per quadrant (minor spot grinding	25.00
472	Gingivectomy or gingivoplasty per quadrant	166.00
473	Osseous and mucogingival surgery per quadrant	350.00
474	Gingivectomy or gingivoplasty, treatment per tooth (fewer than six teeth)	50.00
Endodontics (500-599)		
501	Therapeutic pulpotomy	71.00
502	Vital pulpotomy	71.00
503	Recalcification, includes temporary restoration, per tooth	41.00
511	Anterior root canal therapy; and	215.00
512	Bicuspid root canal therapy; and	260.00
513	Molar root canal therapy	330.00
530	Apicoectomy - surgical procedure in conjunction with root canal filling	300.00
531	Apicoectomy (separate surgical procedure) per tooth	100.00
534	Apexification/Apexogenesis (therapeutic apical closure, per treatment)	100.00
Orthodontic Services (551-599)		
Malocclusion Cases		
551	Initial orthodontic examination/handicapping labio-lingual deviation index	35.00
552	Banding and materials	650.00
554	Per treatment visit - 24 visits maximum. One visit maximum per calendar month.	70.00
556	Quarterly observation 6 quarters maximum	50.00
557	Diagnostic work-up and photographs (additional dental services are listed separately in 22 CCR, Section 51506(b), Procedure Code 112 - intraoral, complete series; and Section 51506.1(b), Procedure Codes 956 and 957 cephalometric head films, including tracing).	100.00
558	Study models	75.00

Procedure Number	Procedure	Maximum Allowance
Cleft Palate Services		
Primary Dentition		
560	Diagnostic work-up - photos, and study models (complete mouth series radiographs, Procedure Code 112, and cephalometric head films, Procedure Codes 956 and 957 including tracing, are separately payable at State fee schedule).	200.00
562	Banding and materials	300.00
564	Per treatment visit - 10 visits maximum. One visit maximum per calendar month.	50.00
Mixed Dentition		
560	Diagnostic work-up - photos, and study models (complete mouth series radiographs, Procedure Code 112, and cephalometric head films, Procedure Codes 956 and 957 including tracing, are separately payable at State fee schedule).	200.00
570	Banding and materials	500.00
572	Per treatment visit - 14 visits maximum. One visit maximum per calendar month	50.00
Permanent Dentition		
560	Diagnostic work-up - photos, and study models (complete mouth series radiographs, Procedure Code 112, and cephalometric head films, Procedure Codes 956 and 957 including tracing, are separately payable at State fee schedule).	200.00
580	Banding and materials	800.00
582	Per treatment visit - 30 visits maximum. One visit maximum per calendar month.	100.00
Facial Growth Management		
590	Diagnostic work-up - photos, and study models (complete mouth series radiographs, Procedure Code 112, and cephalometric head films, Procedure Codes 956 and 957 including tracing, are separately payable at State fee schedule).	100.00
592	Quarterly observation 6 quarters maximum	50.00
594	Progress records prior to treatment	100.00
596	Banding and materials	800.00
598	Per treatment visit 24 visits maximum. One visit maximum per calendar month.	100.00
Malocclusion, Cleft Palate and Facial Growth Management Cases - Retention		
556	Quarterly observation, 6 quarters maximum	50.00
599	Retainer, removable, for each upper and lower	200.00
Restorative Dentistry (600-679)		
Amalgam Restorations		
600	One surface, primary tooth	35.00
601	Two surfaces, primary tooth	43.00
602	Three surfaces, primary tooth	50.00
603	Four or more surfaces, primary tooth (maximum)	57.00
611	One surface, permanent tooth	39.00
612	Two surfaces, permanent tooth	48.00
613	Three surfaces, permanent tooth	57.00
614	Four or more surfaces, permanent tooth (maximum)	60.00

Procedure Number	Procedure	Maximum Allowance
Silicate, Composite, Plastic Restorations		
640	Silicate cement restoration	0.00
641	Silicate restorations, two or more in a single tooth (maximum)	0.00
645	Composite or plastic restoration	55.00
646	Composite or plastic restorations, two or more in a single tooth (maximum)	85.00
648	Pin retention (per pin), maximum three pins per tooth	80.00
Crowns		
650	Crown, plastic (laboratory processed)	150.00
651	Crown, plastic with metal	220.00
652	Crown, porcelain	375.00
653	Crown, porcelain fused to metal	340.00
660	Crown, cast, full	340.00
663	Crown, cast, three quarters	375.00
670	Crown, stainless steel. primary	75.00
671	Crown, stainless steel, permanent	90.00
672	Gold dowel post	75.00
Prosthetics (680-799)		
Pontics		
680	Fixed bridge pontic, cast metal	325.00
681	Fixed bridge pontic, slotted facing	325.00
682	Fixed bridge pontic, slotted pontic	325.00
692	Fixed bridge pontic, porcelain fused to metal	325.00
693	Fixed bridge pontic, plastic processed to metal	325.00
Recementation		
685	Recement inlay, facing, pontic	30.00
686	Recement crown	30.00
687	Recement bridge	50.00
Repairs, Crown, and Bridge		
690	Repair fixed bridge	By Report
694	Replace broken tru-pontic	75.00
695	Replace broken facing, post intact	75.00
696	Replace broken facing, post backing broken	75.00
Removal Prosthodontics		
700	Complete maxillary denture	450.00
701	Complete mandibular denture	450.00
702	Partial upper or lower denture with two assembled wrought wire or cast chrome cobalt clasps with occlusal rests and necessary teeth, acrylic base	415.00
703	Partial upper or lower denture with cast chrome skeleton, two cast clasps, and necessary teeth	400.00
704	Clasp, third and each additional clasp for Procedure 703	40.00
705	Stressbreaker, extra	40.00
706	Partial upper or lower stayplate, acrylic base fee, teeth and clasps extra	150.00
708	Partial upper or lower denture, all acrylic with two assembled wrought wire clasps having two clasp arms, but no rests, and necessary teeth	275.00
709	Clasp, third and each additional for Procedure 708	25.00

Procedure Number	Procedure	Maximum Allowance
712	Clasp, third and each additional for Procedure 702	25.00
716	Clasp or teeth, each for Procedure 706	23.00
720	Denture adjustment, per visit	25.00
721	Reline - office, cold cure	70.00
722	Reline - laboratory processed	140.00
723	Tissue conditioning, per denture	50.00
724	Denture duplication ("jump," "reconstruction"), denture base including necessary tooth replacement, per denture	150.00
Repairs, Dentures, Acrylic		
750	Repair broken denture base only (complete or partial)	45.00
751	Repair broken denture base and replace one broken denture tooth (maximum two)	65.00
752	Each additional denture tooth replaced on 751 repair (maximum two)	15.00
753	Replace one broken denture tooth only (complete or partial)	50.00
754	Each additional denture tooth replaced on 753 repair (maximum two)	15.00
755	Adding first tooth to partial denture to replace newly extracted natural tooth	65.00
756	Each additional natural tooth replaced on 755 repair (maximum two)	30.00
757	Add a new or replace a broken chrome cobalt assembled wrought clasp with two clasp arms and rest to an existing 702 partial denture	75.00
758	Each additional new or replacement clasp for repair 757 (maximum two)	75.00
759	Add a new or replace broken chrome cobalt assembled wrought clasp with two clasp arms and no rest to an existing 708 partial denture	75.00
760	Each additional new or replacement clasp for repair 759 (maximum two)	50.00
761	Reattaching clasp on partial denture, clasp intact, each (maximum two)	60.00
762	Add a new or replace a broken cast chrome cobalt clasp with two clasp arms and rest to an existing 703 partial denture	75.00
763	Each additional new or replacement clasp for repair 762 (maximum two)	75.00
Space Maintainers (Procedures 800-899)		
800	Fixed, unilateral band type space maintainer; (including band)	120.00
801	Removable, plastic - with two stainless steel round wire clasps or rests	230.00
802	Each additional clap or rest (for 801 only)	15.00
811	Fixed, unilateral, stainless steel crown type space maintainer; (including crown, Procedure 670 or 671); space maintainer	111.00
812	Fixed, bilateral, lingual, or palatal bar type space maintainer	200.00
832	Fixed or removable appliance to control harmful habit	221.00
Fractures and Dislocations (*includes usual follow-up care*) (Procedures 900-949)		
900	Maxilla - open reduction, simple	1000.00
901	Maxilla - closed reduction, simple	500.00
902	Mandible - open reduction, simple	1200.00
903	Mandible - closed reduction, simple	700.00
904	Maxilla - closed reduction, compound	800.00
905	Maxilla - open reduction, compound	1200.00
906	Mandible - closed reduction, compound	800.00
907	Mandible - open reduction, compound	1200.00
913	Reduction of dislocation of temporomandibular joint	140.00

Procedure Number	Procedure	Maximum Allowance
915	Treatment of malar fracture, simple, closed reduction	250.00
916	Treatment of malar fracture, simple or compound depressed, open reduction	500.00

Maxillofacial Dental Services (Procedures 950-998)

Diagnostic Services

950	Clinical examination and consultation, including study models	100.00
952	Prosthetic evaluation and treatment plan, including study models	100.00
955	TMJ series radiographs	100.00
956	Cephalometric head film - single, first film, including tracing	50.00
957	Cephalometric head film - each additional film, including tracing	10.00

Maxillofacial Prosthetic Services

960	Speech appliance, transitional, with or without pharyngeal extension	800.00
962	Speech appliance, permanent, edentulous, with or without pharyngealextension	1400.00
964	Speech appliance, permanent, partially edentulous, cast framework, with or without pharyngeal extension	1500.00
966	Palatal lift, interim	800.00
968	Palatal lift permanent, cast framework	1400.00
970	Obturator, immediate surgical, routine	900.00
971	Obturator, immediate surgical, complex	1200.00
972	Obturator, permanent, complex	1500.00
973	Resection prosthesis, permanent, edentulous, complex	1500.00
974	Resection prosthesis, permanent, edentulous, routine	1400.00
975	Resection prosthesis, permanent, partially edentulous, complex	1700.00
976	Repositioner, mandibular, two piece	2300.00
977	Removable facial prosthesis	By Report
978	Splints and stents	By Reporpt
979	Radiation therapy fluoride carrier	80.00
980	Repairs, maxillofacial prosthesis	By Report
981	Rebase, laboratory processed, maxillofacial prosthesis	By Report
982	Balancing (opposing) maxillofacial appliance	By Report
985	Maxillofacial surgical procedures	By Report

Temporamandibular Joint Dysfunction Management

990	Occlusal analysis, including report and/or models	180.00
992	Occlusal adjustments, limited centric and excursive adjustments, including records and/or models	90.00
994	Occlusal balancing, altering centric relation, including records and/or models	400.00
995	Orthopedic stabilizing appliance, disocclusion splint	300.00
996	Postoperative visits, symptomatic care, and counseling	75.00
998	Unlisted therapeutic service	By Report

Unlisted Services

999		By Report

California Medi-Cal Dental Program

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VOLUME 22, NUMBER 13 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 MAY 2006

NEW VERSIONS OF THE PROVIDER APPLICATION AND DISCLOSURE FORMS

All provider application and disclosure forms have been changed to comply with the disclosure requirements of California Code of Regulations, Title 22, Sections 51000.30, 51000.31, 51000.35, and 51000.40. Effective April 17, 2006, the Denti-Cal Program will begin utilizing the same applications used by providers participating in the Medi-Cal Program.

Welfare and Institutions Code (W&I Code) Section 14043.15(a) grants the California Department of Health Services (Department) the authority to adopt regulations for the certification of each applicant and each provider in the Medi-Cal Program.

W&I Code Section 14043.15(b)(1) requires that applicants who are natural persons licensed or certificated under the Business and Professions Code or the Osteopathic or Chiropractic Initiative Acts to provide health care services, or who are professional corporations under subdivision (b) of Section 13401 of the Corporations Code, must enroll in the Medi-Cal Program as either individual providers or as rendering providers in a provider group. This is true even if the person or the professional corporation meets the requirements to qualify as exempt from clinic licensure under subdivision (a) or (m) of Section 1206 of the Health and Safety Code.

W&I Code Section 14043.26(a)(1) requires that an applicant not currently enrolled in the Medi-Cal Program, or a provider applying for continuing enrollment, upon written notification from the Department that enrollment for continued participation of all providers in a specific provider of service category or subgroup of that category to which the provider belongs will occur, or a provider not currently enrolled at a location where the provider intends to provide services, goods, supplies, or merchandise to a Medi-Cal beneficiary, shall submit a complete application package for enrollment, continued enrollment, or enrollment at a new location or a change in location.

Based upon the authority granted to the Director of the Department in W&I Code Section 14043.75(b), the Director hereby designates the following revised applications and disclosure statements that shall be completed by an applicant or provider when required by the California Code of Regulations (CCR), Title 22, Sections 51000.30, 51000.31, 51000.32, 51000.35, and/or 51000.40. This designation is a regulation implementing W&I Code Section 14043.15 and 14043.26 and has the full force and effect of law. This designation is effective for all application and disclosure packages received on or after April 17, 2006. Those applications mailed prior to April 17, 2006 will continue to be processed until June 15, 2006, under the rules and regulations in effect at the time the application and disclosure packages were received.

The applicant or provider, when required pursuant to CCR, Title 22, Sections 51000.30, 51000.31, 51000.32, 51000.35, and/or 51000.40, shall complete and submit, as applicable, the following applications and forms:

- ✓ Medi-Cal Provider Group Application - DHS 6203 (Rev. 1/06)
- ✓ Medi-Cal Provider Application - DHS 6204 (Rev. 1/06)

- ✓ Medi-Cal Disclosure Statement - DHS 6207 (Rev. 1/06)
- ✓ Medi-Cal Provider Agreement - DHS 6208 (Rev. 1/06)
- ✓ Medi-Cal Supplemental Changes - DHS 6209 (Rev. 1/06)
- ✓ Medi-Cal Rendering Provider Application/Disclosure Statement/Agreement for Physician/Allied/Dental Providers - DHS 6216 (Rev. 1/06)
- ✓ Successor Liability with Joint and Several Liability Agreement - DHS 6217 (Rev. 1/06)

Providers have two options to receive the new enrollment application forms:

1) Effective April 17, 2006, download the applications from the California Medi-Cal Web site at http://www.medi-cal.ca.gov. Go to Provider Enrollment; Application Forms. Applications shall only be printed on one side, not duplexed (i.e., double-sided).
2) Contact the Denti-Cal Telephone Service Center at (800) 423-0507 and request that an application package be mailed.

If you have any further questions regarding the new enrollment applications, please call Denti-Cal at (800) 423-0507.

California Medi-Cal Dental Program

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VOLUME 22, NUMBER 14 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 MAY 2006

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

National Provider Identifier (NPI) Update

Denti-Cal is currently assessing its present systems to comply with the HIPAA regulations for implementing the NPI. Denti-Cal providers, dental plans, and clearinghouses must begin using/accepting the NPI on all HIPAA electronic covered transactions beginning May 23, 2007.

Providers must continue utilizing their existing Denti-Cal provider numbers until further notice.

Providers may apply for an NPI by:

- ✓ Visiting the Web site at http://nppes.cms.hhs.gov, or
- ✓ Mailing a completed paper application to the address found at the above Web site, or
- ✓ Calling (800) 465-3203 or (800) 692-2326 (TTY).

For more general information about the NPI, please visit the Web site for the Centers for Medicare & Medicaid Services (CMS) at http://www.cms.hhs.gov/NationalProvIdentStand.

Current Dental Terminology (CDT)

CDT has been delayed pending the final approval of Manual of Criteria (MOC) regulations, which is a State legislative process. As a result, CDT codes are not accepted by Denti-Cal at this time. Any claim service line (CSL) submitted with a CDT procedure code, an invalid procedure code, or a blank procedure code field, will be denied.

As additional information becomes available, Denti-Cal will release it to providers.

$1,800 LIMIT PER CALENDAR YEAR FOR BENEFICIARY SERVICES (DENTAL CAP)

The California Department of Health Services has implemented changes in covered benefits. Section 14080 of the Welfare and Institutions Code indicates that from January 1, 2006 through January 1, 2009, non-exempt dental services to beneficiaries 21 years of age and above will be capped at $1,800 per beneficiary for each calendar year.

Providers are responsible to check the beneficiary cap status prior to rendering services to determine the current remaining balance. This information can be accessed by telephoning Denti-Cal toll-free at (800) 423-0507.

To help reduce the possibility that procedures performed will not be fully paid because the dental cap has been reached, providers should

- ✓ verify the beneficiary cap.

- ✓ discuss with beneficiary any other treatment recently received from another provider.
- ✓ quickly submit claims for procedures not requiring prior authorization.
- ✓ upon receipt of a Notice of Authorization (NOA), promptly perform services and submit requests for payment.

Debits toward the cap are based upon the order in which claims/NOAs are processed. Authorization does not guarantee payment. Non-exempt services will be paid in the order they are received and processed until the annual cap is reached for a calendar year.

Adjudication Reason Codes 501 and 502, created to assist in the processing of claims, read as follows:

501 Per documentation, service does not qualify as an emergency. Paid amount is applied towards the beneficiary services dental cap. Payment for this service reflects the maximum allowable amount as beneficiary services dental cap may have been met.

502 Per documentation, service qualifies as an emergency. Paid amount has not been applied towards the beneficiary services dental cap.

Two new policy codes have been created to determine whether claim service lines (CSLs) submitted as emergency services are, or are not, emergency services.

Policy Code 58 reads as follows:

58 Emergency services documentation is insufficient, bene cap applied.

Policy Code 59 reads as follows:

59 Bene cap not applied. Documentation of services qualifies as an emergency.

For additional information, please consult the four previous bulletins detailing this subject: Volume 21, Numbers 34, 35, 36, and Volume 22, Number 10.

DENTI-CAL NO LONGER PROCESSES COUNTY MEDICAL SERVICES PROGRAM (CMSP) DENTAL SERVICES

Providers are reminded that, since October 1, 2005, Doral Dental Services of California, the dental services subcontractor for Blue Cross Life & Health Insurance Company (Blue Cross), is administering CMSP.

Providers are also reminded that, effective April 1, 2006, all claims submitted for CMSP, whatever the date of service, will be denied by Denti-Cal.

The following adjudication reason code has been created for claims received after April 1, 2006:

387 Payment disallowed. The request for CMSP dental services was not received before April 1, 2006. Contact Doral Dental Services of California (1-800-341-8478).

The following new policy code has been created for CMSP dental services:

71 Payment denied. Time limitation for submitting CMSP claims has expired.

SUBMISSION REQUIREMENTS FOR SPECIALIST CONSULTATION (PROCEDURE 040)

Providers are reminded of the criteria for Procedure 040. Per the Denti-Cal Manual of Criteria, Procedure 040 is described as follows:

1. A consultation for diagnostic purposes is a benefit to dental providers who are recognized in any of the dental specialties providing:
    a. The specialist is not the dentist providing the treatment, and
    b. A copy of the specialist's report accompanies the claim.
2. This procedure is not a benefit for normal referrals from one practitioner to another for continued treatment by a specialist.

The specialist's report shall be a copy of the interoffice report the specialist sends to the referring dentist. It must be dated, contain the name and address of the referring dentist, and contain adequate documentation as to the specialist's clinical findings and treatment recommendations.

If the specialist's report indicates that the specialist has treated, or plans to treat the referred patient, the request for payment for Procedure 040 will be denied. When treatment is required by the specialist, Procedure 010 (Examination, Initial Episode of Treatment Only) should be billed for the initial consultation.

REMINDER: UPCOMING DENTI-CAL SEMINARS

In June 2006 these seminars are offered. If in your area, please consider attending, then phone Denti-Cal toll-free at (800) 423-0507 to make a reservation.

June 9, 2006	D050/Workshop	Morgan Hill
June 16, 2006	D051/Workshop	Fresno
June 22, 2006	D052/Basic Seminar and EDI Overview	San Bernardino
June 23, 2006	D053/Advanced Seminar	San Bernardino
June 29, 2006	D054/Workshop	Fullerton
June 30, 2006	D055/Advanced Seminar	Fullerton

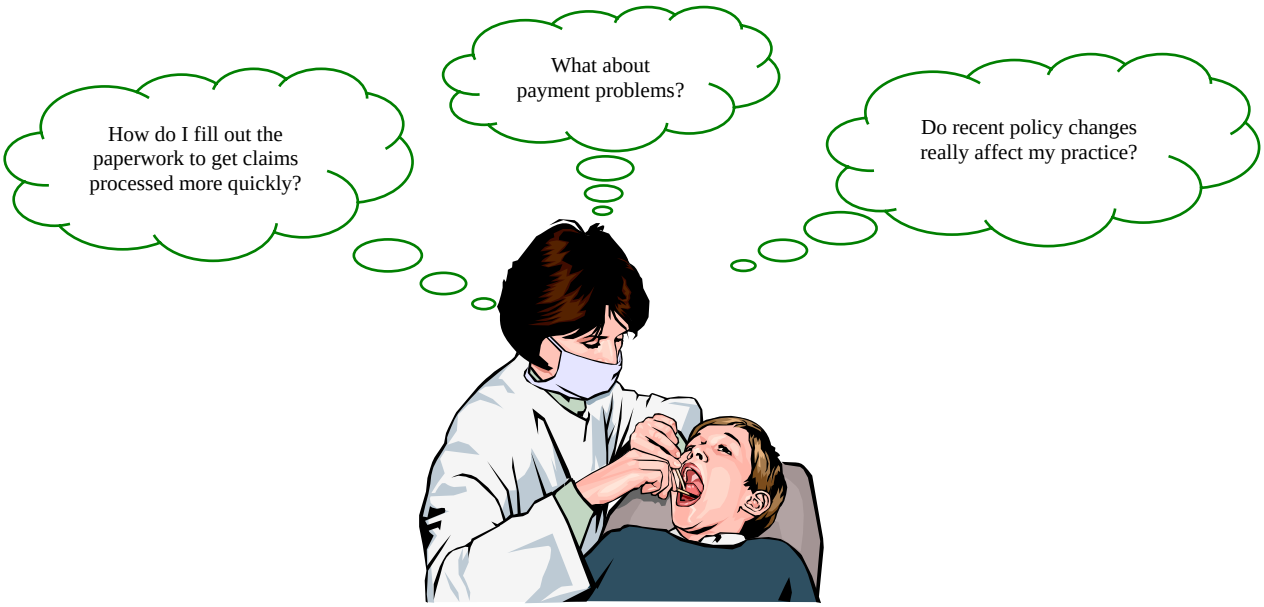
If there are questions about any of the above, please call Denti-Cal toll-free at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 22, NUMBER 15 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 MAY 2006

SEMINAR SCHEDULE FOR THIRD QUARTER, 2006



Basic Seminars

- Introduction to California Medi-Cal Dental Program
- Enrollment and Eligibility
- Proper Billing Procedures
- The Bakersfield seminar has been expanded to include an overview of Electronic Data Interchange (EDI)

Workshops

- Enrollment and Eligibility
- Criteria and Current Changes
- Hands-On Forms Completion
- HIPAA Informational Updates

Advanced Seminars

- Criteria Presented *by* a Dentist *for* Dentists and Staff
- View Actual Treatment Slides

Orthodontic Seminars

- Designed for Denti-Cal providers who limit their practice to orthodontics only
- Comprehensive information on certification, enrollment, billing procedures and criteria

ABOUT THE SEMINARS AND WORKSHOPS

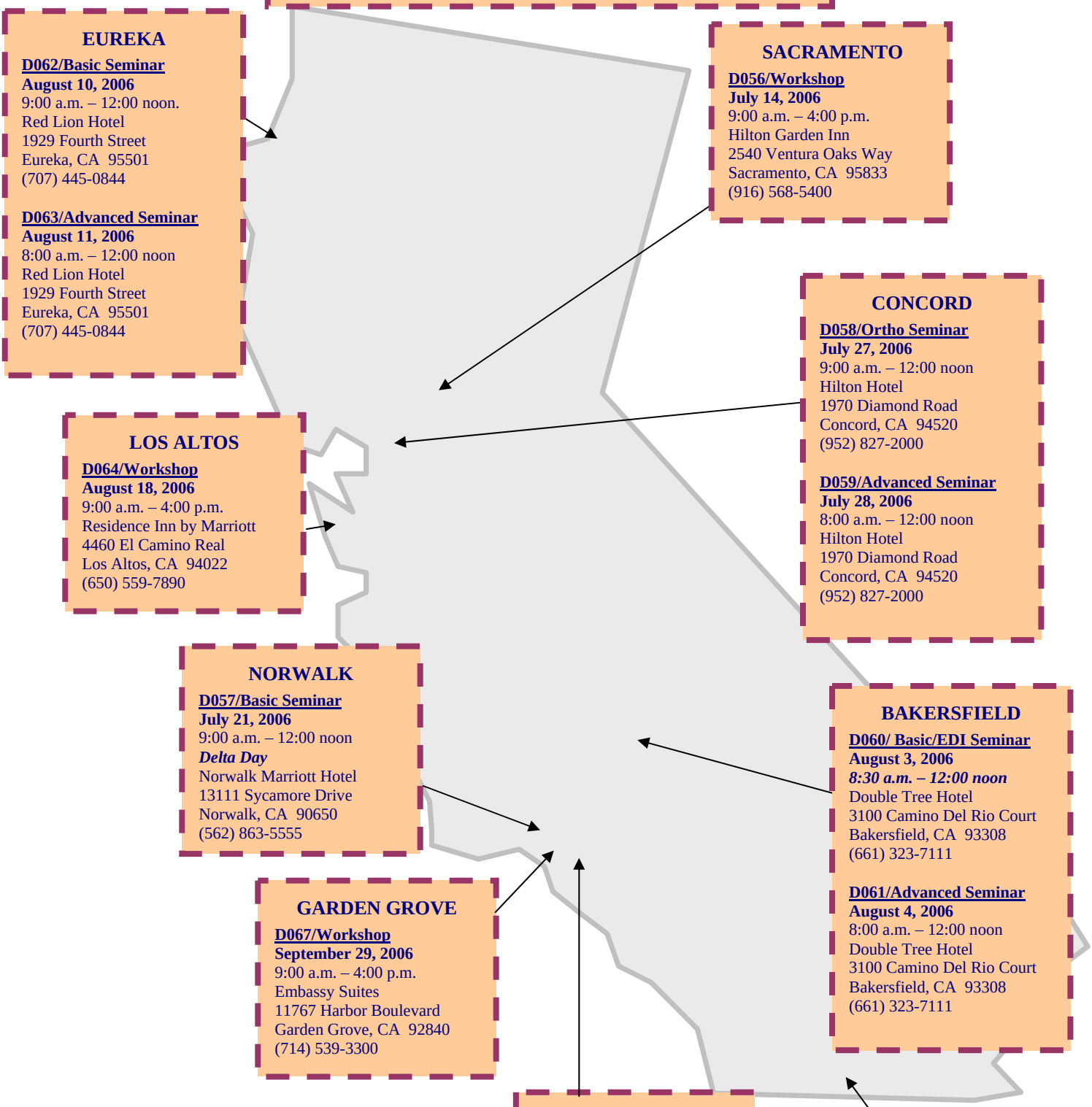
- Seminars and workshops are offered *free of charge*.
- Sessions begin *on time*, so arrive early.
- Bring your updated *Denti-Cal Provider Manual* to get the most from the training.
- Audio/video recording is not allowed.
- Billing information is subject to change.
- Reservations ensure that a space is available for you! Likewise, please let us know if you are unable to attend.
- Continuing education credits are available:

Basic Seminars	3 CE credits
Advanced Seminars	4 CE credits
Workshops	6 CE credits
Orthodontic Seminars	3 CE credits

- Some facilities may charge for parking.
- The use of cell phones during the seminar is strongly discouraged. If you must be available for calls, please be courteous and set the ringer on vibrate.

For additional information, questions and to register, please phone Denti-Cal toll free at 800/423-0507.

Denti-Cal Seminar Schedule
Third Quarter 2006



EUREKA

D062/Basic Seminar
August 10, 2006
9:00 a.m. – 12:00 noon.
Red Lion Hotel
1929 Fourth Street
Eureka, CA 95501
(707) 445-0844

D063/Advanced Seminar
August 11, 2006
8:00 a.m. – 12:00 noon
Red Lion Hotel
1929 Fourth Street
Eureka, CA 95501
(707) 445-0844

SACRAMENTO

D056/Workshop
July 14, 2006
9:00 a.m. – 4:00 p.m.
Hilton Garden Inn
2540 Ventura Oaks Way
Sacramento, CA 95833
(916) 568-5400

CONCORD

D058/Ortho Seminar
July 27, 2006
9:00 a.m. – 12:00 noon
Hilton Hotel
1970 Diamond Road
Concord, CA 94520
(952) 827-2000

D059/Advanced Seminar
July 28, 2006
8:00 a.m. – 12:00 noon
Hilton Hotel
1970 Diamond Road
Concord, CA 94520
(952) 827-2000

LOS ALTOS

D064/Workshop
August 18, 2006
9:00 a.m. – 4:00 p.m.
Residence Inn by Marriott
4460 El Camino Real
Los Altos, CA 94022
(650) 559-7890

NORWALK

D057/Basic Seminar
July 21, 2006
9:00 a.m. – 12:00 noon
Delta Day
Norwalk Marriott Hotel
13111 Sycamore Drive
Norwalk, CA 90650
(562) 863-5555

BAKERSFIELD

D060/ Basic/EDI Seminar
August 3, 2006
8:30 a.m. – 12:00 noon
Double Tree Hotel
3100 Camino Del Rio Court
Bakersfield, CA 93308
(661) 323-7111

D061/Advanced Seminar
August 4, 2006
8:00 a.m. – 12:00 noon
Double Tree Hotel
3100 Camino Del Rio Court
Bakersfield, CA 93308
(661) 323-7111

GARDEN GROVE

D067/Workshop
September 29, 2006
9:00 a.m. – 4:00 p.m.
Embassy Suites
11767 Harbor Boulevard
Garden Grove, CA 92840
(714) 539-3300

TEMECULA

D066/Workshop
September 22, 2006
9:00 a.m. – 4:00 p.m.
Embassy Suites
29345 Rancho California Road
Temecula, CA 92591
(951) 676-5656

EL CENTRO

D065/Basic Seminar
August 25, 2006
9:00 a.m. – 12:00 noon
Holiday Inn Express
350 Smoketree Drive
El Centro, CA 92243
(760) 352-6666

DENTI-CAL PROVIDER TRAINING SEMINAR RESERVATION FORM

TYPE OF SEMINAR:

☐ Basic Seminar
(Seminar Code Number:_____)

☐ Workshop
(Seminar Code Number:_____)

☐ Advanced Seminar
(Seminar Code Number:_____)

☐ Ortho Seminar
(Seminar Code Number:_____)

Seating for all seminars is limited, so reserve your place today by returning this reservation form in the enclosed envelope to Denti-Cal. Be sure to include the seminar code number and indicate the names of staff who will be attending. Denti-Cal is unable to confirm your reservation by mail, so be sure to note the date and time on your calendar. ***To help us keep administrative costs down and continue to offer you free educational seminars, we request that you notify Denti-Cal toll-free at (800) 423-0507 in the event you need to cancel your reservation.***

PLEASE TYPE OR PRINT CLEARLY

Yes, I/my office staff wish to attend the Denti-Cal provider training seminar(s) indicated above. The name(s) of the person(s) attending are:

1._____ 4._____

2._____ 5._____

3._____ 6._____

In the area below, please type or print the dentist's name and office address:

_____ Provider No.:_____

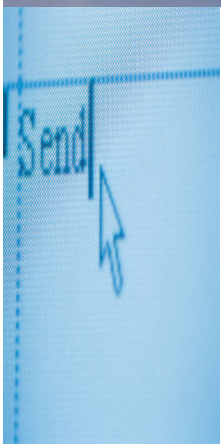
_____

_____ Phone No.:_____

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 22, NUMBER 16 P .O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 MAY 2006



Learn About Electronic Claims Submission!

ELECTRONIC DATA INTERCHANGE SEMINARS

3rd Quarter Schedule

Electronic Data Interchange (EDI) seminars provide a general introduction to electronic claims submission and helpful tips for offices currently submitting claims electronically. These *FREE* presentations cover the advantages of EDI, how electronic claims are processed, how to best utilize electronic reports and other practical hints.

Third Quarter 2006 Seminar Schedule

DATE:	CITY:	TIME:	LOCATION:
July 21	*Norwalk*	*1:15 pm to 4:15 pm*	*Norwalk Marriot* 13111 Sycamore Dr. (562) 863-5555

Seating is limited.
For reservations, please call Denti-Cal toll-free at
(800) 423-0507.

Continuing education credits from the Academy of General Dentistry are available.

California Medi-Cal Dental Program

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VOLUME 22, NUMBER 17 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 JUNE 2006

DENTI-CAL MODIFIES ADJUDICATION REASON CODE 325 FOR PURPOSES OF THE $1,800 LIMIT PER CALENDAR YEAR BENEFICIARY SERVICES (DENTAL CAP)

Adjudication Reason Code 325 has been modified to assist in processing and reads as follows:

325 Per documentation, service does not qualify as an emergency. For adult beneficiaries, payment may reflect the maximum allowable under the beneficiary services dental cap.

CLARIFICATION OF $1,800 LIMIT PER CALENDAR YEAR FOR BENEFICIARY SERVICES (DENTAL CAP)

The California Department of Health Services has implemented changes in covered benefits to be set forth as follows: The fiscal year (FY) 2005-2006 Budget Act requires the California Department of Health Services to employ changes in covered benefits as set forth in Assembly Bill 131 (Chapter 80, Statutes of 2005). Assembly Bill 131 amends Section 14080 of the Welfare and Institutions Code by limiting non-exempt dental services for beneficiaries 21 years of age or older to $1,800 per beneficiary for each calendar year beginning January 1, 2006 and lasting through January 1, 2009.

Providers are responsible to check the beneficiary cap status prior to rendering services to determine the current remaining balance. This information can be accessed by telephoning Denti-Cal toll-free at (800) 423-0507.

To help reduce the possibility that procedures performed will not be fully paid because the dental cap has been reached, providers should

- ✓ verify the beneficiary cap.
- ✓ discuss with beneficiary any other treatment recently received from another provider.
- ✓ quickly submit claims for procedures not requiring prior authorization.
- ✓ upon receipt of a Notice of Authorization (NOA), promptly perform services and submit requests for payment.

Providers are reminded that *approval of a Treatment Authorization Request (TAR) does not guarantee payment*. Debits toward the cap are based upon the order in which claims and NOAs are processed. Non-exempt services will be paid in the order they are received and processed until the annual cap is reached for a calendar year. *Payments will not be applied towards the $1,800 per calendar year limit for 1) Long Term Care; 2) pregnancy-related procedures; 3) services related to emergency treatment; and 4) exempt procedures.*

Adjudication Reason Codes 500, 501 and 502, created to assist in the processing of claims, read as follows:

500 Payment for this service reflects the maximum allowable amount as beneficiary services dental cap has been met.

501 Per documentation, service does not qualify as an emergency. Paid amount is applied towards the beneficiary services dental cap. Payment for this service

reflects the maximum allowable amount as beneficiary services dental cap may have been met.

502 Per documentation, service qualifies as an emergency. Paid amount has not been applied towards the beneficiary services dental cap.

Two new policy codes have been created to determine whether claim service lines (CSLs) submitted as emergency services are, or are not, emergency services.

Policy Code 58 reads as follows:

58 Emergency services documentation is insufficient. Bene cap applied.

Policy Code 59 reads as follows:

59 Bene cap not applied. Documentation of services qualifies as an emergency.

Long-Term Care

Beneficiaries will be excluded from this limitation if they have Long Term Care (LTC) aid codes *or* reside in either Place of Service 4/SNF (Skilled Nursing Facility) or Place of Service 5/ICF (Intermediate Care Facility). The following LTC aid codes will be exempt:

Denti-Cal Long-Term Care (LTC) Aid Codes	
Aid Code 13	Full
Aid Code 23	Full
Aid Code 53	Restricted to LTC services only
Aid Code 63	Full

Additional Exempt Aid Codes

The following aid codes will always be exempt from the limitation:

Additional Exempt Aid Codes	
Aid Code 50	County Medical Services Program
Aid Code 84	County Medical Services Program
Aid Code 85	County Medical Services Program
Aid Code 88	County Medical Services Program
Aid Code 89	County Medical Services Program
Aid Code 8E	Accelerated Medi-Cal for Children
Aid Code 8F	County Medical Services Program
Aid Code 9G	General Relief/General Assistance
Aid Code 9H	Healthy Families Child
Aid Code 9J	Genetically Handicapped Persons Program
Aid Code 9K	California Children Services
Aid Code 9M	California Children Services
Aid Code 9N	California Children Services
Aid Code 9R	California Children Services
Aid Code 9X	Foster Care Ineligible - County Funds

Pregnancy-Related Services

Pregnant beneficiaries will also be excluded from the limitation, *when pregnancy-related procedure codes are requested along with a pregnancy-related aid code.* The exempt pregnancy-related aid codes and pregnancy-related services are as follows:

Denti-Cal Pregnancy-Related Aid Codes	
Aid Code 0U	Restricted Services
Aid Code 0V	Limited
Aid Code 2Y	Limited Term Reinstatement
Aid Code 3T	Restricted to pregnancy and emergency services
Aid Code 3V	Restricted to pregnancy and emergency services
Aid Code 44	Restricted to pregnancy-related services
Aid Code 48	Restricted to pregnancy-related services
Aid Code 55	Restricted to pregnancy and emergency services
Aid Code 58	Restricted to pregnancy and emergency services
Aid Code 5J	Restricted Services
Aid Code 5F	Restricted to pregnancy and emergency services
Aid Code 5R	Restricted Services
Aid Code 5T	Restricted to pregnancy and emergency services
Aid Code 5W	Restricted to pregnancy and emergency services
Aid Code 5Y	Restricted to pregnancy and emergency services
Aid Code 6U	Restricted to pregnancy and emergency services
Aid Code 7C	Restricted to pregnancy and emergency services
Aid Code 7G	Valid only for ambulatory prenatal care services
Aid Code 7K	Restricted to pregnancy and emergency services
Aid Code 7N	Valid for Minor Consent services
Aid Code 8T	Restricted to pregnancy and emergency services

Denti-Cal Procedure Codes for Pregnancy-Related Services	
Procedure 010	Complete Examination, Initial Episode of Treatment Only
Procedure 015	Examination Periodic (Annual)
Procedure 049	Prophylaxis, Beneficiaries Through Age 12
Procedure 050	Prophylaxis, Beneficiaries 13 Years of Age and Over
Procedure 062	Prophylaxis, Including Topical Application of Fluoride, Beneficiaries Ages 6 through 17 Years of Age
Procedure 452	Subgingival Curettage and Root Planing, Per Full Mouth Treatment
Procedure 453	Occlusal Adjustment (Limited) per Quadrant (Minor Spot Grinding)
Procedure 472	Gingivectomy or Gingivoplasty Per Quadrant
Procedure 473	Osseous and Mucogingival Surgery Per Quadrant
Procedure 474	Gingivectomy or Gingivoplasty, Treatment Per Tooth (Fewer Than Six Teeth)

Emergency Services

As a reminder, an emergency dental condition is a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, which in the absence of immediate dental attention could reasonably be expected to result in any of the following: placing the patient's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. The emergency must be certified by the dental provider in accordance with Section 51056 of Title 22, California Code of Regulations. The Department of Health Services may review the provider's decision that an emergency existed and that the services were medically necessary.

The following procedure codes may also be exempt from the limitation if they are related to an adequately documented emergency service.

Denti-Cal Procedure Codes for Emergency Services	
Procedure 020	Office Visit During Regular Office Hours, for Treatment and/or Observation of Teeth or Supporting Structures
Procedure 030	Professional Visit After Regular Office Hours or to Bedside
Procedure 035	Hospital Care
Procedure 040	Specialist Consultation
Procedure 080	Emergency Treatment, Palliative
Procedure 110	Intraoral Periapical, Single, First Radiograph
Procedure 111	Intraoral Periapical, Each Additional Radiograph
Procedure 113	Intraoral, Occlusal Radiograph
Procedure 114	Extraoral, Single, Head or Lateral Jaw
Procedure 115	Extraoral, Each Additional Head or Lateral Jaw
Procedure 116	Bitewings, Two Radiographs
Procedure 117	Bitewings, Four Radiographs
Procedure 118	Bitewings, Anterior, One Radiograph
Procedure 125	Panographic Film, Single Radiograph
Procedure 150	Biopsy of Oral Tissue
Procedure 160	Gross and Microscopic Histopathologic Examination
Procedure 200	Removal of Erupted Tooth, Uncomplicated, First Tooth
Procedure 201	Removal of Erupted Tooth (Teeth), Uncomplicated, Each Additional Tooth
Procedure 202	Removal of Erupted Tooth, Surgical
Procedure 203	Removal of Root or Root Tip Completely Covered by Bone
Procedure 204	Removal of Root or Root Tip Not Totally Covered by Bone
Procedure 220	Postoperative Visit, Complications, e.g., Osteitis
Procedure 230	Removal of Impacted Tooth, Soft Tissue
Procedure 231	Removal of Impacted Tooth, Partial Bony
Procedure 232	Removal of Impacted Tooth, Complete Bony
Procedure 259	Excision of Hyperplastic Tissue, Per Arch
Procedure 260	Incision and Drainage of Abscess, Intraoral
Procedure 261	Incision and Drainage of Abscess, Extraoral

Denti-Cal Procedure Codes for Emergency Services	
Procedure 262	Excision Pericoronal Gingiva (Operculectomy)
Procedure 263	Sialolithotomy, Intraoral
Procedure 264	Sialolithotomy, Extraoral
Procedure 265	Closure of Salivary Fistula
Procedure 266	Dilation of Salivary Duct
Procedure 269	Excision of Benign Tumor, Up to 1.25 cm
Procedure 270	Excision of Benign Tumor, Larger Than 1.25 cm
Procedure 271	Excision of Malignant Tumor
Procedure 273	Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Permanent Teeth and/or Alveolus
Procedure 276	Removal of Foreign Body From Bone (Independent Procedure)
Procedure 277	Radical Resection of Bone for Tumor with Bone Graft
Procedure 278	Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign Body
Procedure 279	Oral Antral Fistula Closure
Procedure 280	Excision of Cyst up to 1.25 cm
Procedure 281	Excision of Cyst over 1.25 cm
Procedure 282	Sequestrectomy
Procedure 290	Excision of Foreign Body, Soft Tissue
Procedure 292	Suture of Soft Tissue Wound or Injury
Procedure 300	Therapeutic Drug Injection
Procedure 301	Conscious Sedation, Relative Analgesia (Nitrous Oxide), Per Visit
Procedure 400	General Anesthesia
Procedure 451	Emergency Treatment (Periodontal Abscess, Acute Periodontitis, etc.)
Procedure 501	Therapeutic Pulpotomy
Procedure 502	Vital Pulpotomy
Procedure 503	Recalcification, Includes Temporary Restoration, Per Tooth
Procedure 685	Recement Inlay, Facing, Pontic
Procedure 686	Recement Crown
Procedure 695	Replace Broken Facing, Post Backing Broken
Procedure 687	Recement Bridge
Procedure 690	Repair Fixed Bridge
Procedure 694	Replace Broken Tru-Pontic
Procedure 696	Replace Broken Facing, Post Backing Broken
Procedure 750	Repair Broken Denture Base Only (Complete or Partial)

Denti-Cal Procedure Codes for Emergency Services	
Procedure 754	Each Additional Denture Tooth Replaced on 753 Repair (Maximum Two)
Procedure 755	Adding First Tooth to Partial Denture to Replace Newly Extracted Natural Tooth
Procedure 751	Repair Broken Denture Base and Replace One Broken Denture Tooth (Maximum Two)
Procedure 752	Each Additional Denture Tooth Replaced on 751 Repair (Maximum Two)
Procedure 753	Replace One Broken Denture Tooth Only (Complete or Partial)
Procedure 756	Each Additional Natural Tooth Replaced on 755 Repair (Maximum Two)
Procedure 757	Add a New or Replace Broken Chrome Cobalt Assembled Wrought Clasp with Two Clasp Arms and Rest to an Existing 702 Partial Denture
Procedure 758	Each Additional New or Replacement Clasp for Repair 757 (Maximum Two)
Procedure 759	Add a New or Replace Broken Chrome Cobalt Assembled Wrought Clasp with Two Clasp Arms and No Rest to an Existing 708 Partial Denture
Procedure 760	Each Additional New or Replacement Clasp for Repair 759 (Maximum Two)
Procedure 761	Reattaching Clasp on Partial Denture, Clasp Intact, Each (Maximum Two)
Procedure 762	Add a New Clasp or Replace a Broken Cast Chrome Cobalt Clasp With Two Clasp Arms and Rest to an Existing 703 Partial Denture
Procedure 763	Each Additional New or Replacement Clasp for Repair 762 (Maximum Two)
Procedure 900	Maxilla - Open Reduction, Simple
Procedure 901	Maxilla - Closed Reduction, Simple
Procedure 902	Mandible - Open Reduction, Simple
Procedure 903	Mandible - Closed Reduction, Simple
Procedure 904	Maxilla - Closed Reduction, Compound
Procedure 905	Maxilla - Open Reduction, Compound
Procedure 906	Mandible - Closed Reduction, Compound
Procedure 907	Mandible - Open Reduction, Compound
Procedure 913	Reduction of Dislocation of Temporomandibular Joint
Procedure 915	Treatment of Malar Fracture, Simple, Closed Reduction
Procedure 916	Treatment of Malar Fracture, Simple or Compound Depressed, Open Reduction

Denti-Cal Exempt Procedure Codes

The following procedure codes will always be exempt from the limitation:

Denti-Cal Exempt Procedure Codes	
Procedure 299	Unlisted Surgical Service or Procedure
Procedure 700	Complete Maxillary Denture
Procedure 701	Complete Mandibular Denture

Denti-Cal Exempt Procedure Codes	
Procedure 702	Partial Upper or Lower Denture With Two Assembled Wrought Wire or Cast Chrome Cobalt Clasps With Occlusal Rests and Necessary Teeth, Acrylic Base
Procedure 703	Partial Upper or Lower Denture With Cast Chrome Skeleton, Two Cast Clasps, and Necessary Teeth
Procedure 704	Clasp, Third and Each Additional Clasp for Procedure 703
Procedure 705	Stressbreaker, Extra
Procedure 706	Partial Upper or Lower Stayplate, Acrylic Base Fee, Teeth and Clasps Extra
Procedure 708	Partial Upper or Lower Denture, All Acrylic With Two Assembled Wrought Wire Clasps having Two Clasp Arms, But No Rests, and Necessary Teeth
Procedure 709	Clasp, Third and Each Additional for Procedure 708
Procedure 712	Clasp, Third and Each Additional for Procedure 702
Procedure 722	Reline Laboratory Processed
Procedure 724	Denture Duplication ("Jump", "Reconstruction"), Denture Base Including Necessary Tooth Replacement, Per Denture
Procedure 960	Speech appliance, transitional, with or without pharyngeal extension
Procedure 962	Speech appliance, permanent, edentulous, with or without pharyngeal extension
Procedure 964	Speech appliance, permanent, partially edentulous, cast framework, with or without pharyngeal extension
Procedure 966	Palatal lift, interim
Procedure 968	Palatal lift, permanent cast framework
Procedure 970	Obturator, immediate surgical, routine
Procedure 971	Obturator, immediate surgical, complex
Procedure 972	Obturator, permanent, complex
Procedure 973	Resection prosthesis, permanent, edentulous, complex
Procedure 974	Resection prosthesis, permanent, edentulous, routine
Procedure 975	Resection prosthesis, permanent, partially edentulous, complex
Procedure 976	Repositioner, mandibular, two piece
Procedure 977	Removable facial prosthesis
Procedure 978	Splints and stents
Procedure 979	Radiation therapy fluoride carrier
Procedure 980	Repairs, maxillofacial prosthesis
Procedure 981	Rebase, laboratory processed maxillofacial prosthesis
Procedure 982	Balancing (opposing) maxillofacial appliance
Procedure 985	Maxillofacial surgical procedures
Procedure 998	Unlisted therapeutic service
Procedure 999	Unlisted procedures

All other aid codes and procedure codes will be subject to the $1,800 calendar year limitation. If the annual cap has been met and nothing has been paid on a procedure, providers are allowed to bill beneficiaries their usual and customary fees.

For questions regarding any of the above, please contact Denti-Cal toll-free at (800) 423-0507.

California Medi-Cal Dental Program

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HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

National Provider Identifier (NPI) Update

Only 10 months until the NPI compliance date!
Do you have your NPI?

Denti-Cal providers, dental plans, and clearinghouses *must* begin accepting the NPI on all HIPAA electronic covered transactions beginning May 23, 2007.

Providers must continue utilizing their existing Denti-Cal provider numbers until further notice.

Providers may apply for an NPI in one of three ways:

- ✓ Visiting the Web site at http://nppes.cms.hhs.gov;
- ✓ Mailing a completed paper application to the address found at the above Web site;
- ✓ Calling (800) 465-3203 or (800) 692-2326 (TTY).

For more general information about the NPI, please visit the Web site for the Centers for Medicare & Medicaid Services (CMS) at http://www.cms.hhs.gov/NationalProvIdentStand and for frequently asked questions:

http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=bI-syZ8i

Current Dental Terminology (CDT)

CDT continues to be delayed pending the final approval of Manual of Criteria (MOC) regulations via the State legislative process.

CDT codes will not be accepted by Denti-Cal at this time. Any claim service line (CSL) submitted with a CDT procedure code, an invalid procedure code, or a blank procedure code field will be denied.

If there are any questions, please call Denti-Cal toll-free at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 22, NUMBER 20 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 JULY 2006

FURTHER ENHANCEMENTS TO DENTI-CAL'S TELEPHONE INTERACTIVE VOICE RESPONSE (IVR) SYSTEM

Denti-Cal's Interactive Voice Response (IVR) System has been enhanced.

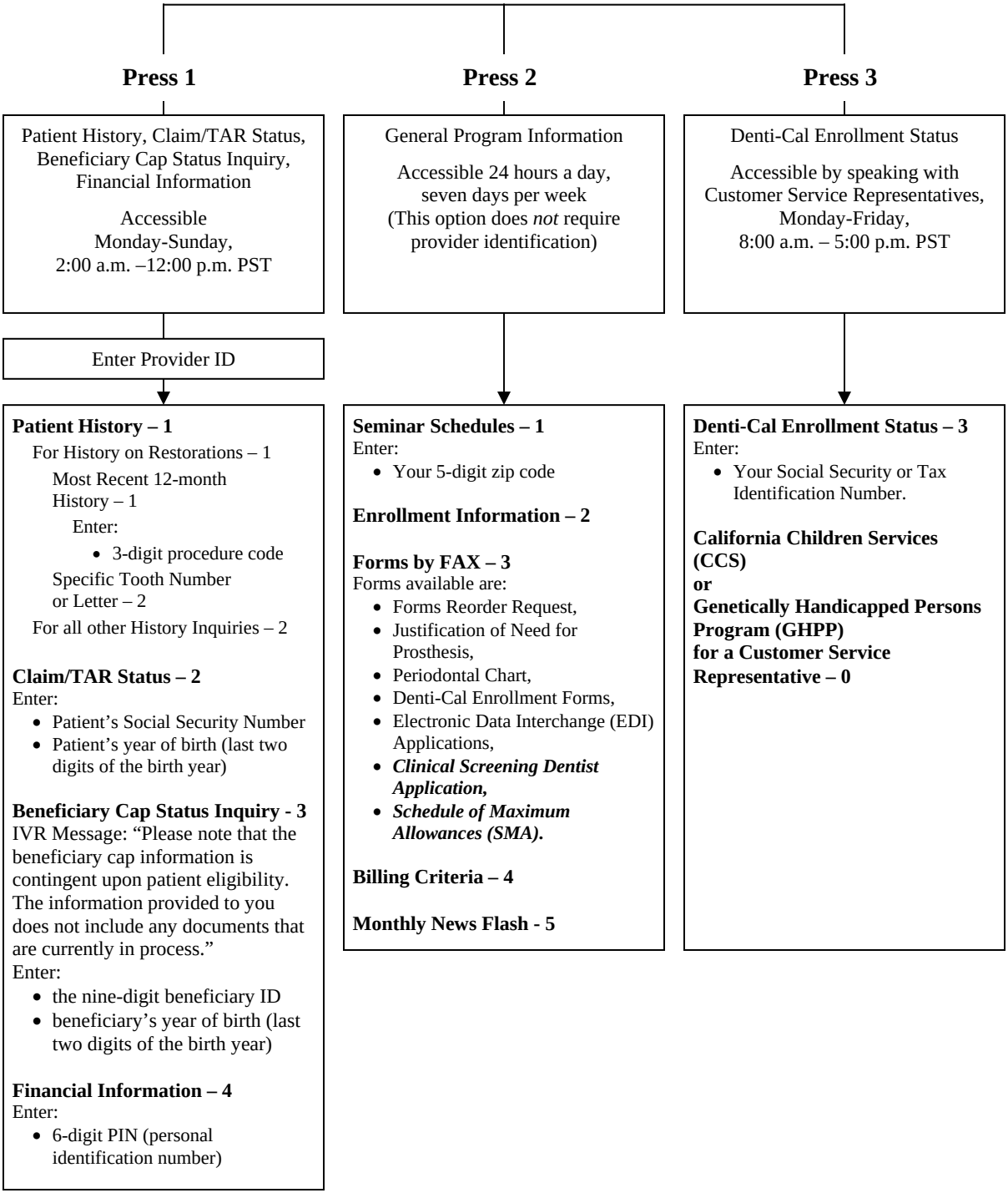
- Providers may now request by FAX: the Schedule of Maximum Allowances (SMA) and the clinical screening dentist application.

- In addition to details regarding basic and advanced seminars, providers may now get information on orthodontic seminars and workshops.

- Changes to the IVR allow providers to verify the available balance of a beneficiary's dental cap. For information regarding beneficiary cap status, press 1, then press 3, and follow the prompts. Providers are reminded that beneficiary cap information is contingent upon patient eligibility and does *not* include any documents currently in process.

Providers are also reminded to continue checking beneficiary eligibility by using the Automated Eligibility Verification System (AEVS), by calling (800) 456-2387.

Provider Toll-Free Menu Options (800) 423-0507



If there are any questions, please call Denti-Cal toll-free at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 22, NUMBER 21 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 JULY 2006

DENTI-CAL WEB SITE ADDRESS CHANGE

Coming this August! The Denti-Cal Web site address will change to www.denti-cal.ca.gov. Available for use 24 hours/day, seven days/week, the Web site is designed to provide access to information of great benefit to provider offices.

Some of its features are:

- ✓ Access to provider and Electronic Data Interchange (EDI) enrollment descriptions and forms.
- ✓ Access to provider and beneficiary resources links.
- ✓ Access to provider publications.
- ✓ Access to seminar schedules.
- ✓ Access to the Denti-Cal provider referral list.

In addition, the Web site will include:

- ✓ The ability to view frequently asked questions and answers.
- ✓ The ability to view documentation related to billing criteria and information.
- ✓ The ability to view information regarding outreach services.
- ✓ The ability to view information related to managed care.

The Web site will also include the toll-free telephone numbers and indicate when each page was last updated, a site help page, a site map, and outbound links.

Using the Denti-Cal Web site is easy for both providers and beneficiaries. All that's needed is Internet access and Microsoft Windows Internet Explorer® version 5.5 and above, or Netscape Navigator® version 4.0 and above. Adobe Acrobat® is also necessary in order to use the information on the Web site. A free Adobe Reader® can be downloaded by clicking on the Web site toolbox link.

For additional information, please call Denti-Cal toll-free at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 22, NUMBER 22 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 AUGUST 2006

MEDI-CAL IDENTIFICATION CARD FOR PRESUMPTIVE ELIGIBILITY

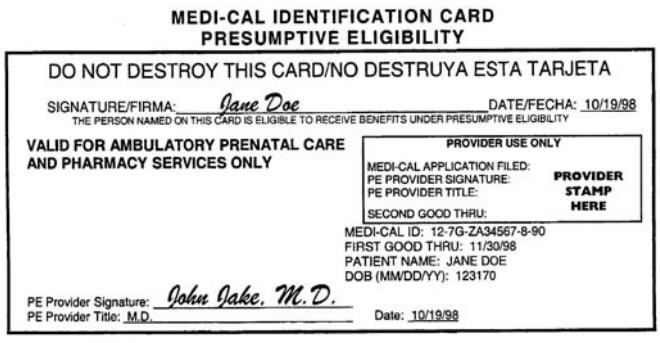
In order to receive payment for services provided to beneficiaries in Aid Code 7G, providers must submit a copy of the beneficiary's temporary Presumptive Eligibility (PE) card with their claim (see below for a sample of the card). This card is validated by the beneficiary's physician attending to her pregnancy and is valid through the last day of the month following the month in which PE is determined. This date is identified on the temporary PE card as the "First Good Thru" date. Some beneficiaries may be eligible for extended PE coverage. In such cases, the temporary PE card will have a "Second Good Thru" date, and sometimes additional "Good Thru" dates.

Providers will only be paid for claims with dates of service that are between the effective date (the date the beneficiary signs the card) and the latest "Good Thru" date. The date of service must be within the validated timeframe and, if not, providers should instruct the beneficiary to see her prenatal care provider, call her Eligibility Worker and/or a community advocate.

In most cases, beneficiaries are covered under Presumptive Eligibility for up to 4 months; however, the *physician* may obtain approval for an extension from the PE Support Unit. A call to the woman's physician can confirm that PE has been extended beyond 4 months.

Non-emergency Services: Pregnant women in Aid Code 7G are eligible to receive the following non-emergency dental services. Prior authorization is *not* required. It is only necessary to indicate "pregnant" in the Comments area (box 34) when submitting claims for procedures 010, 015, 049, 050, 062, 452, 453, 472, 473, and 474. For additional information, please see Denti-Cal Bulletin Volume 21, Number 41, released in December 2005.

Emergency Services: *A clinical emergency certification statement is required* and, when applicable, radiographs and/or other documentation to justify the procedure must be included when submitting claims for emergency procedures 020, 030, 035, 040, 080, 110, 111, 113, 114, 115, 116, 117, 118, 125, 150, 160, 200, 201, 202, 203, 204, 220, 230, 231, 232, 259, 260, 261, 262, 263, 264, 265, 266, 269, 270, 271, 273, 276, 277, 278, 279, 280, 281, 282, 290, 292, 299, 300, 301, 400, 451, 501, 502, 503, 511, 512, 513, 530, 531, 600, 601, 602, 603, 611, 612, 613, 614, 640, 641, 645, 646, 648, 670, 671, 672, 685, 686, 687, 690, 694, 695, 696, 716, 720, 721, 723, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 900, 901, 902, 903, 904, 905, 906, 907, 913, 915, and 916. *Simply stating "Pregnant" for these emergency procedures is insufficient and the claim will be denied.* For additional information, please see Denti-Cal Bulletin Volume 21, Number 41, released in December 2005.



MEDI-CAL IDENTIFICATION CARD
PRESUMPTIVE ELIGIBILITY

DO NOT DESTROY THIS CARD/NO DESTRUYA ESTA TARJETA

SIGNATURE/FIRMA: Jane Doe DATE/FECHA: 10/19/98
THE PERSON NAMED ON THIS CARD IS ELIGIBLE TO RECEIVE BENEFITS UNDER PRESUMPTIVE ELIGIBILITY

VALID FOR AMBULATORY PRENATAL CARE AND PHARMACY SERVICES ONLY

PROVIDER USE ONLY
MEDI-CAL APPLICATION FILED:
PE PROVIDER SIGNATURE:
PE PROVIDER TITLE:
SECOND GOOD THRU:
PROVIDER STAMP HERE

MEDI-CAL ID: 12-7G-ZA34567-8-90
FIRST GOOD THRU: 11/30/98
PATIENT NAME: JANE DOE
DOB (MM/DD/YY): 123170

PE Provider Signature: John Jake, M.D.
PE Provider Title: M.D. Date: 10/19/98

If there are any questions, please call Denti-Cal toll-free at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 22, NUMBER 23 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 AUGUST 2006

IMPORTANT UPDATE: CHANGES IN ADJUDICATION PROCEDURES/REASON CODES FOR DENTAL RESTORATIONS IMPLEMENTED

In 2004, AB 1762 amended Welfare and Institutions (W&I) Code 14132.88(f) to require pretreatment radiograph documentation for post treatment claims to establish the medical necessity for dental restorations (fillings and prefabricated/stainless steel crowns) and to reduce fraudulent claims for unnecessary restorative services. Additional and/or modified adjudication reason codes will clarify the reasons why Denti-Cal may disallow a request for treatment and/or payment.

Denti-Cal has created the following adjudication reason codes to present a more detailed explanation as to why a restoration has been disallowed:

121a Neither radiographs nor photographs substantiate immediate need for restoration of surface(s) requested.

293d Reevaluate for extraction of primary tooth. Radiolucency evident in periapical or furcation area.

271j Primary tooth has deep caries that appears to encroach the pulp. Radiograph inadequate to evaluate periapical or furcation area.

266m Current periapical radiographs of the tooth along with arch films to establish arch integrity are required.

029g Payment/Authorization disallowed due to radiographs/photographs dated in the future.

Denti-Cal has modified the following adjudication reason codes for dental restorations and associated procedures to assist with processing of claims:

029e Payment denied. Date(s) on radiographs/photographs are dated after the date of service.

121 Radiographs do not substantiate immediate need for restoration of surface(s) requested.

266g Unable to evaluate treatment. Photographs, digitized images, paper copies, or duplicate radiographs are not labeled adequately to determine right or left or individual tooth numbers.

124a Decay not evident on the requested surface(s), but decay evident on other surface(s).

271i Permanent tooth has deep caries that appears to encroach the pulp. Periapical is required.

For additional information please telephone Denti-Cal toll-free at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 22, NUMBER 24 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 AUGUST 2006

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

National Provider Identifier (NPI) Update

Only 9 months until the NPI compliance date!
Do you have your NPI?

Denti-Cal providers, dental plans, and clearinghouses *must* begin submitting the NPI on all HIPAA electronic covered transactions beginning May 23, 2007.

Providers must continue utilizing their existing Denti-Cal provider numbers until further notice.

Providers may apply for an NPI in one of three ways:

- ✓ Visiting the Web site at http://nppes.cms.hhs.gov;
- ✓ Mailing a completed paper application to the address found at the above Web site;
- ✓ Calling (800) 465-3203 or (800) 692-2326 (TTY).

For more general information about the NPI, please visit the Web site for the Centers for Medicare & Medicaid Services (CMS) at http://www.cms.hhs.gov/NationalProvIdentStand and for frequently asked questions:

http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=bI-syZ8i

Current Dental Terminology (CDT)

CDT continues to be delayed pending the final approval of Manual of Criteria (MOC) regulations via the State legislative process.

CDT codes will not be accepted by Denti-Cal at this time. Any claim service line (CSL) submitted with a CDT procedure code, an invalid procedure code, or a blank procedure code field will be denied.

VERIFY YOUR TAX IDENTIFICATION NUMBER

The California Medi-Cal Dental Program (Denti-Cal) reports annually to the Internal Revenue Service (IRS) the amount paid to each enrolled billing provider. The Business Name and Tax Identification Number (TIN) must match **exactly** with the name and TIN on file with the IRS. If the Business Name and TIN **do not** match, the IRS requires Denti-Cal to withhold 31% of future payments.

Tax Identification Number

The TIN may either be a Social Security Number (SSN) or an employer identification number (EIN). Denti-Cal uses the TIN to report earnings to the IRS, which are printed on the front of the check and on the Explanation of Benefits (EOB) you receive from Denti-Cal. **Please verify that the Business Name and TIN on the next check/EOB you receive from Denti-Cal are correct.** If the Business Name and TIN appearing on your Denti-Cal check/EOB are correct, you do not need to notify Denti-Cal.

Updating Your Tax Identification Number

If the Business Name and/or TIN are incorrect, a Medi-Cal Supplemental Changes - DHS 6209 (Rev. 1/06) form is required to make necessary changes. Please attach a valid, legible copy of an official document **from** the IRS (Form 147-C, SS-4 Confirmation Notification, 2363 or 8109C).

- If your business type has changed (for example: sole proprietorship, corporation or partnership) you will be required to complete a new Medi-Cal Provider Group Application - DHS 6203 (Rev. 1/06) or a Medi-Cal Provider Application - DHS 6204 (Rev. 1/06), Medi-Cal Disclosure Statement - DHS 6207 (Rev. 1/06), and Medi-Cal Provider Agreement - DHS 6208 (Rev 1/06).
- If you are incorporated, attach a valid, legible copy of the Articles of Incorporation showing the name of your corporation and a legible copy of an official document **from** the IRS (Form 147-C, SS-4 Confirmation Notification, 2363 or 8109-C).

If your corporation is doing business under a fictitious name, attach a valid, legible copy of the fictitious name permit issued by the Dental Board of California.

To obtain a current application form, please contact Denti-Cal toll-free at (800) 423-0507 or visit the Medi-Cal Web site: www.medi-cal.ca.gov. Failure to submit the appropriate form and supporting documents will delay the processing of your application and will be returned as incomplete.

OPTICAL CHARACTER RECOGNITION (OCR)/INTELLIGENT CHARACTER RECOGNITION (ICR)

With goals to improve processing time and responsiveness to provider and beneficiary inquiries, Denti-Cal implemented new claims-processing technology in June 2005.

Now that Denti-Cal has been using the OCR/ICR technology for over a year, we have become aware of provider submission patterns that are incompatible with the new processing system.

For optimum results, we ask that you follow the specifications listed below. Failure to do so could possibly result in misadjudicated documents or processing delays.

Do

- **Use a laser printer for best results.** If handwritten documents must be submitted, use neat block letters, black ink, and stay within the field boundaries.
- **Use a 10 point font.** Smaller fonts may result in potential misread by the scanners.
- **Submit notes and attachments on 8 ½" by 11" paper.** Small attachments must be taped to standard paper in order to go through the scanner.
- **Submit notes and attachments on one side of the paper only.** Double-sided attachments require copying and additional preparation for the scanners.
- **Enter quantity information in the quantity field.** OCR does not read the description of service field to pick up the quantity.
- **Complete boxes 19 and 20**. Enter the complete Billing Provider Name, Provider Number, and Service Office Number to ensure appropriate payment to the correct billing number.

Do Not

- **Do not place additional forms, attachments, documentation, periodontal charts, or DC-054** (Justification for Prosthesis) **forms inside the x-ray envelope.** Once the attachment is discovered, substantial manual effort is required to associate the attachment to the original claim or Treatment Authorization Request (TAR) form. This results in an unavoidable delay in adjudication.
- **Do not use the carbon claims or TAR forms with the attached x-ray envelope. These are the DC-001A, DC-001B, DC-001C, and DC-001D.** Processing these documents is manually labor intensive. The scanners have difficulty reading the carbon print. The carbon leaves residue inside the scanners, resulting in more frequent service calls. The form itself must be trimmed to scanner size, and the envelope must be hand addressed. **Please discard these forms.**

The items listed above have been identified as outstanding submission issues that result in substantial processing delays. For a full list of specifications and helpful billing hints for OCR/ICR, please refer to Denti-Cal Bulletin Volume 21, Number 28, issued July 2005.

PREVENTION OF IDENTITY THEFT

To prevent identity theft, the California Department of Health Services (CDHS) strongly encourages all providers to avoid using a beneficiary's Social Security Number (SSN) whenever possible, including for the purposes of administrative billing and submission of Treatment Authorization Requests (TARs).

When submitting claims and TARs to Denti-Cal, providers should use the 14-character ID number from the Benefits Identification Card.

CDHS recognizes the importance of protecting the identity and the health information of beneficiaries and is currently working on system changes that will prevent the use of SSNs on Denti-Cal claims and TARs.

VISIT DENTI-CAL AND ELECTRONIC DATA INTERCHANGE (EDI) BOOTHS AT SAN FRANCISCO CALIFORNIA DENTAL ASSOCIATION (CDA) SCIENTIFIC SESSION

Be sure to visit Denti-Cal, Outreach, and Electronic Data Interchange (EDI) at the CDA Scientific Session in San Francisco, Friday, September 15, 2006 through Sunday, September 17, 2006. Look for Denti-Cal Provider Relations staff in booth 725, with Denti-Cal Outreach and representatives from Denti-Cal's EDI program in booth 727. Both booths are on the first floor of the West Exhibit Hall in the Moscone Center.

DENTI-CAL SEMINARS SCHEDULED FOR SEPTEMBER:

D066/Workshop	September 22, 2006	Temecula
D067/Workshop	September 29, 2006	Garden Grove

MEDI-CAL DENTAL PATIENT REFERRAL SERVICE

Medi-Cal Dental Program (Denti-Cal) providers can take advantage of a free referral service for accepting Medi-Cal dental patients. This referral service can be an excellent resource for enrolled Denti-Cal providers to build, maintain, or increase their patient base while making available the highest level of dental service for the state's medically needy.

If you are a provider interested in this service, or need to update the information currently on file, please fill out the attached Medi-Cal Dental Patient Referral Service Form and mail it to:

California Medi-Cal Dental Program
Enrollment Department
P.O. Box 15609
Sacramento, CA 95852-0609

If there are questions regarding this information, please call Denti-Cal toll-free at (800) 423-0507.

Denti-Cal
California Medi-Cal Dental Program

Medi-Cal Dental Patient Referral Service

Dear Doctor:

The Medi-Cal Dental Program (Denti-Cal) offers a voluntary patient referral service that serves the dental community statewide. Please consider our request to include your office on our referral list for Denti-Cal patients.

Complete this form and return it to the Denti-Cal in the enclosed envelope.

If you have any questions about the Medi-Cal Dental Patient Referral Service, please do not hesitate to call Denti-Cal toll-free (800) 423-0507.

Sincerely,
Provider Services
Medi-Cal Dental Program
Denti-Cal

☐ Yes I would like Denti-Cal patients referred to my office. Please add my name to your referral list. I understand I may request removal of my name from this list at any time.

☐ No I do not want Denti-Cal patients referred to my office. Please do not include my name on your referral list.

Provider Name: _____ Billing Provider ID: _____ Service Office #: ____

Business Name: _____

Fictitious Name: _____

Office Address: _____

Office Telephone: (____) _____ Is your office wheelchair accessible? ☐ Yes ☐ No

What other languages are spoken in your office? _____

List any dental specialties or services offered in your office (i.e., endodontic, periodontal, oral surgical procedures, general anesthesia, etc.): _____

What age group of children does your office see? ☐ 5 & under ☐ 6 – 12 ☐ 13 & older

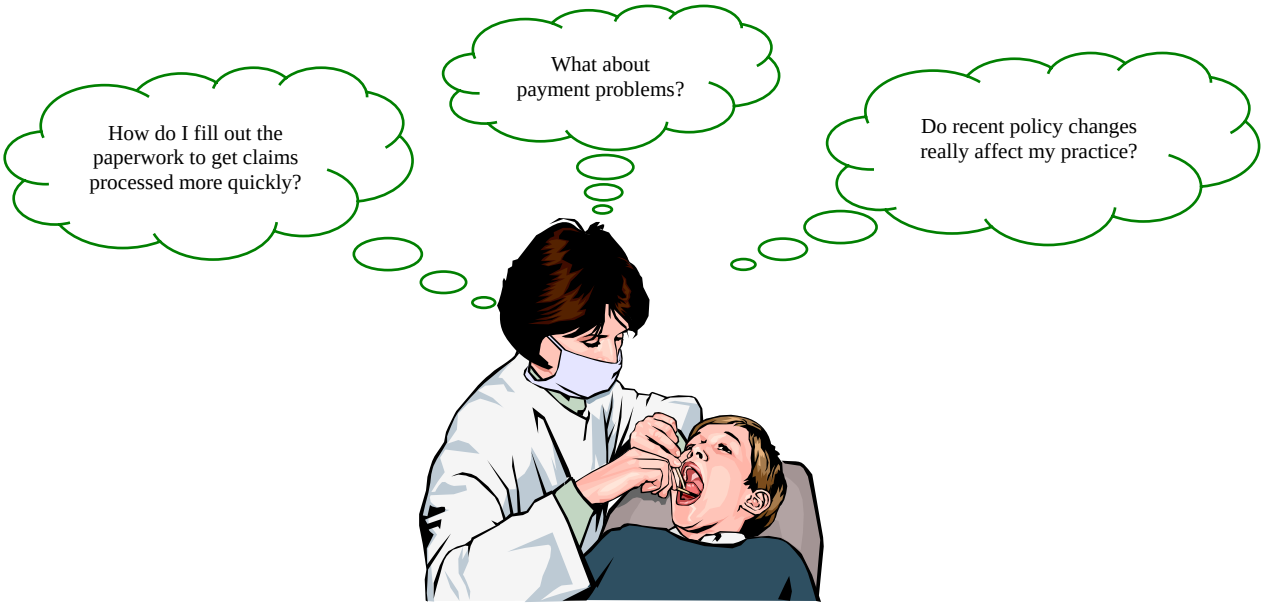
Billing Provider Signature: _____ **Date:** _____

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 22, NUMBER 25 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 AUGUST 2006

SEMINAR SCHEDULE FOR FOURTH QUARTER, 2006



Basic Seminars

- Introduction to California Medi-Cal Dental Program
- Enrollment and Eligibility
- Proper Billing Procedures
- The Stockton seminar has been expanded to include an overview of Electronic Data Interchange (EDI)

Workshops

- Enrollment and Eligibility
- Criteria and Current Changes
- Hands-On Forms Completion
- HIPAA Informational Updates

Advanced Seminars

- Criteria Presented *by* a Dentist *for* Dentists and Staff
- View Actual Treatment Slides

Orthodontic Seminars

- Designed for Denti-Cal providers who limit their practice to orthodontics only
- Comprehensive information on certification, enrollment, billing procedures and criteria

ABOUT THE SEMINARS AND WORKSHOPS

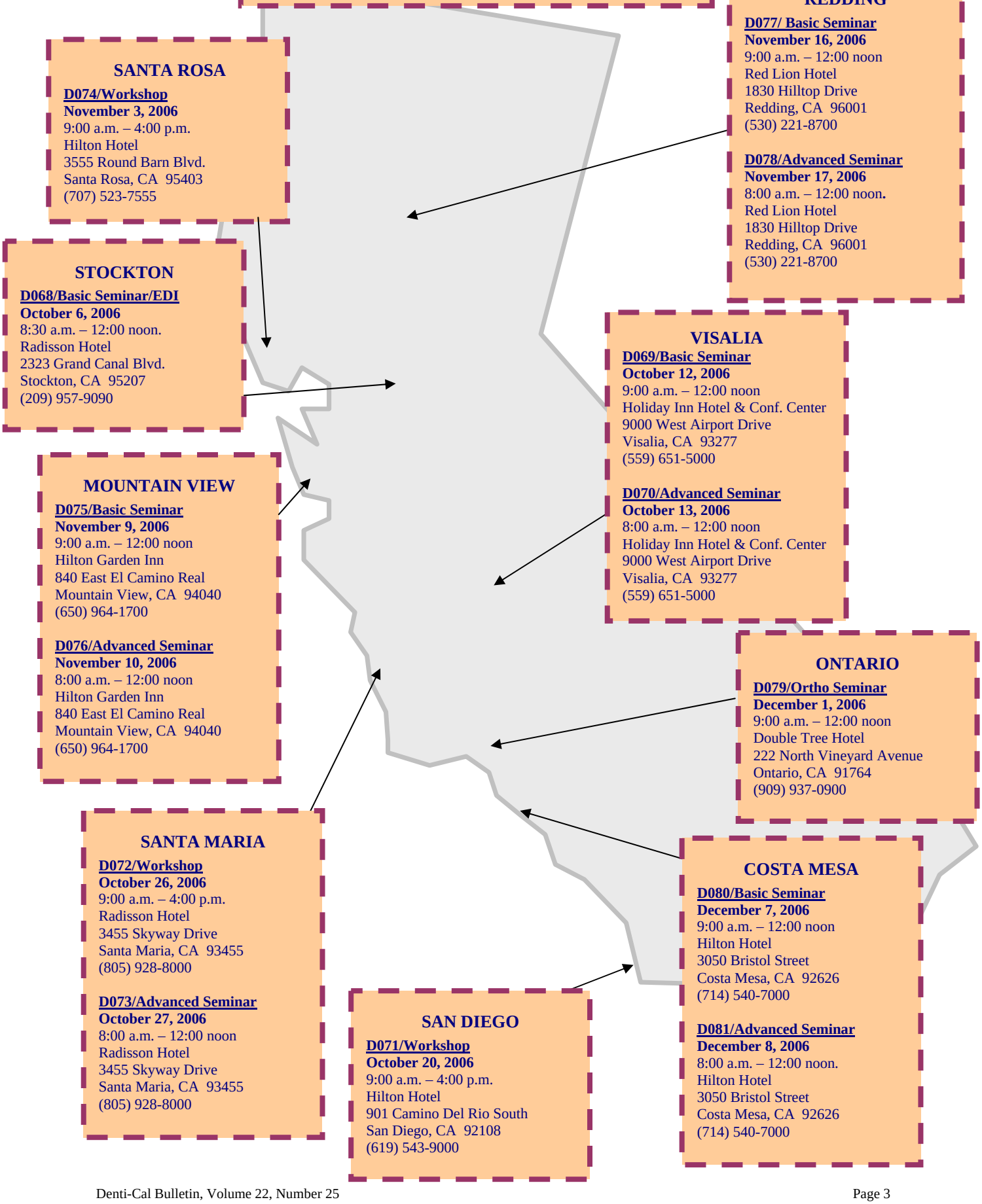
- Seminars and workshops are offered *free of charge*.
- Sessions begin *on time*, so arrive early.
- Bring your updated *Denti-Cal Provider Manual* to get the most from the training.
- Audio/video recording is not allowed.
- Billing information is subject to change.
- Reservations ensure that a space is available for you! Likewise, please let us know if you are unable to attend.
- Continuing education credits are available:

Basic Seminars	3 CE credits
Advanced Seminars	4 CE credits
Workshops	6 CE credits
Orthodontic Seminars	3 CE credits

- Some facilities may charge for parking.
- The use of cell phones during the seminar is strongly discouraged. If you must be available for calls, please be courteous and set the ringer on vibrate.

For additional information, questions and to register, please phone Denti-Cal toll-free at 800/423-0507.

Denti-Cal Seminar Schedule
Fourth Quarter 2006



REDDING

D077/ Basic Seminar
November 16, 2006
9:00 a.m. – 12:00 noon
Red Lion Hotel
1830 Hilltop Drive
Redding, CA 96001
(530) 221-8700

D078/Advanced Seminar
November 17, 2006
8:00 a.m. – 12:00 noon.
Red Lion Hotel
1830 Hilltop Drive
Redding, CA 96001
(530) 221-8700

SANTA ROSA

D074/Workshop
November 3, 2006
9:00 a.m. – 4:00 p.m.
Hilton Hotel
3555 Round Barn Blvd.
Santa Rosa, CA 95403
(707) 523-7555

STOCKTON

D068/Basic Seminar/EDI
October 6, 2006
8:30 a.m. – 12:00 noon.
Radisson Hotel
2323 Grand Canal Blvd.
Stockton, CA 95207
(209) 957-9090

VISALIA

D069/Basic Seminar
October 12, 2006
9:00 a.m. – 12:00 noon
Holiday Inn Hotel & Conf. Center
9000 West Airport Drive
Visalia, CA 93277
(559) 651-5000

D070/Advanced Seminar
October 13, 2006
8:00 a.m. – 12:00 noon
Holiday Inn Hotel & Conf. Center
9000 West Airport Drive
Visalia, CA 93277
(559) 651-5000

MOUNTAIN VIEW

D075/Basic Seminar
November 9, 2006
9:00 a.m. – 12:00 noon
Hilton Garden Inn
840 East El Camino Real
Mountain View, CA 94040
(650) 964-1700

D076/Advanced Seminar
November 10, 2006
8:00 a.m. – 12:00 noon
Hilton Garden Inn
840 East El Camino Real
Mountain View, CA 94040
(650) 964-1700

ONTARIO

D079/Ortho Seminar
December 1, 2006
9:00 a.m. – 12:00 noon
Double Tree Hotel
222 North Vineyard Avenue
Ontario, CA 91764
(909) 937-0900

SANTA MARIA

D072/Workshop
October 26, 2006
9:00 a.m. – 4:00 p.m.
Radisson Hotel
3455 Skyway Drive
Santa Maria, CA 93455
(805) 928-8000

D073/Advanced Seminar
October 27, 2006
8:00 a.m. – 12:00 noon
Radisson Hotel
3455 Skyway Drive
Santa Maria, CA 93455
(805) 928-8000

COSTA MESA

D080/Basic Seminar
December 7, 2006
9:00 a.m. – 12:00 noon
Hilton Hotel
3050 Bristol Street
Costa Mesa, CA 92626
(714) 540-7000

D081/Advanced Seminar
December 8, 2006
8:00 a.m. – 12:00 noon.
Hilton Hotel
3050 Bristol Street
Costa Mesa, CA 92626
(714) 540-7000

SAN DIEGO

D071/Workshop
October 20, 2006
9:00 a.m. – 4:00 p.m.
Hilton Hotel
901 Camino Del Rio South
San Diego, CA 92108
(619) 543-9000

DENTI-CAL PROVIDER TRAINING SEMINAR RESERVATION FORM

TYPE OF SEMINAR:

☐ Basic Seminar
(Seminar Code Number:_____)

☐ Workshop
(Seminar Code Number:_____)

☐ Advanced Seminar
(Seminar Code Number:_____)

☐ Ortho Seminar
(Seminar Code Number:_____)

Seating for all seminars is limited, so reserve your place today by returning this reservation form in the enclosed envelope to Denti-Cal. Be sure to include the seminar code number and indicate the names of staff who will be attending. Denti-Cal is unable to confirm your reservation by mail, so be sure to note the date and time on your calendar. ***To help us keep administrative costs down and continue to offer you free educational seminars, we request that you notify Denti-Cal toll-free at (800) 423-0507 in the event you need to cancel your reservation.***

PLEASE TYPE OR PRINT CLEARLY

Yes, I/my office staff wish to attend the Denti-Cal provider training seminar(s) indicated above. The name(s) of the person(s) attending are:

1._____ 4._____

2._____ 5._____

3._____ 6._____

In the area below, please type or print the dentist's name and office address:

_____ Provider No.:_____

_____

_____ Phone No.:_____

_____

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 22, NUMBER 26 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 SEPTEMBER 2006

FURTHER CLARIFICATION OF $1,800 LIMIT PER CALENDAR YEAR FOR BENEFICIARY SERVICES (DENTAL CAP)

Several procedures, once classified as requiring documentation to be paid as emergency services under the dental cap, have been identified as always exempt from the dental cap limitation. Those procedures are 150, 160, 260, 261, 263, 264, 265, 266, 269, 270, 271, 273, 276, 277, 278, 279, 280, 281, 282, 292, 685, 686, 687, 690, 694, 695, 696, 900, 901, 902, 903, 904, 905, 906, 907, 913, 915, and 916. For a complete list of both exempt and emergency procedure codes and their descriptions, please see the tables below.

The California Department of Health Services has implemented changes in covered benefits to be set forth as follows: The fiscal year (FY) 2005-2006 Budget Act requires the California Department of Health Services to employ changes in covered benefits as set forth in Assembly Bill 131 (Chapter 80, Statutes of 2005). Assembly Bill 131 amends Section 14080 of the Welfare and Institutions Code by limiting non-exempt dental services for beneficiaries 21 years of age or older to $1,800 per beneficiary for each calendar year beginning January 1, 2006 and lasting through January 1, 2009.

Providers are responsible to check the beneficiary cap status prior to rendering services to determine the current remaining balance. This information can be accessed by telephoning Denti-Cal toll-free at (800) 423-0507.

To help reduce the possibility that procedures performed will not be fully paid because the dental cap has been reached, providers should

- ✓ verify the beneficiary cap.
- ✓ discuss with beneficiary any other treatment recently received from another provider.
- ✓ quickly submit claims for procedures not requiring prior authorization.
- ✓ upon receipt of a Notice of Authorization (NOA), promptly perform services and submit requests for payment.

Providers are reminded that *approval of a Treatment Authorization Request (TAR) does not guarantee payment*. Debits toward the cap are based upon the order in which claims and NOAs are processed. Non-exempt services will be paid in the order they are received and processed until the annual cap is reached for a calendar year. *Payments will not be applied towards the $1,800 per calendar year limit for 1) Long Term Care; 2) pregnancy-related procedures; 3) services related to emergency treatment; and 4) exempt procedures.*

Exempt Procedure Codes

Denti-Cal Procedure Codes Exempt from the Dental Cap	
Procedure 150	Biopsy of Oral Tissue
Procedure 160	Gross and Microscopic Histopathologic Examination
Procedure 260	Incision and Drainage of Abscess, Intraoral
Procedure 261	Incision and Drainage of Abscess, Extraoral

Denti-Cal Procedure Codes Exempt from the Dental Cap	
Procedure 263	Sialolithotomy, Intraoral
Procedure 264	Sialolithotomy, Extraoral
Procedure 265	Closure of Salivary Fistula
Procedure 266	Dilation of Salivary Duct
Procedure 269	Excision of Benign Tumor, Up to 1.25 cm
Procedure 270	Excision of Benign Tumor, Larger Than 1.25 cm
Procedure 271	Excision of Malignant Tumor
Procedure 273	Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Permanent Teeth and/or Alveolus
Procedure 276	Removal of Foreign Body From Bone (Independent Procedure)
Procedure 277	Radical Resection of Bone for Tumor with Bone Graft
Procedure 278	Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign Body
Procedure 279	Oral Antral Fistula Closure
Procedure 280	Excision of Cyst up to 1.25 cm
Procedure 281	Excision of Cyst over 1.25 cm
Procedure 282	Sequestrectomy
Procedure 292	Suture of Soft Tissue Wound or Injury
Procedure 299	Unlisted Surgical Service or Procedure
Procedure 685	Recement Inlay, Facing, Pontic
Procedure 686	Recement Crown
Procedure 687	Recement Bridge
Procedure 690	Repair Fixed Bridge
Procedure 694	Replace Broken Tru-Pontic
Procedure 695	Replace Broken Facing, Post Backing Broken
Procedure 696	Replace Broken Facing, Post Backing Broken
Procedure 700	Complete Maxillary Denture
Procedure 701	Complete Mandibular Denture
Procedure 702	Partial Upper or Lower Denture With Two Assembled Wrought Wire or Cast Chrome Cobalt Clasps With Occlusal Rests and Necessary Teeth, Acrylic Base
Procedure 703	Partial Upper or Lower Denture With Cast Chrome Skeleton, Two Cast Clasps, and Necessary Teeth
Procedure 704	Clasp, Third and Each Additional Clasp for Procedure 703
Procedure 705	Stressbreaker, Extra
Procedure 706	Partial Upper or Lower Stayplate, Acrylic Base Fee, Teeth and Clasps Extra
Procedure 708	Partial Upper or Lower Denture, All Acrylic With Two Assembled Wrought Wire Clasps having Two Clasp Arms, But No Rests, and Necessary Teeth
Procedure 709	Clasp, Third and Each Additional for Procedure 708
Procedure 712	Clasp, Third and Each Additional for Procedure 702

Denti-Cal Procedure Codes Exempt from the Dental Cap	
Procedure 722	Reline Laboratory Processed
Procedure 724	Denture Duplication ("Jump", "Reconstruction"), Denture Base Including Necessary Tooth Replacement, Per Denture
Procedure 900	Maxilla - Open Reduction, Simple
Procedure 901	Maxilla - Closed Reduction, Simple
Procedure 902	Mandible - Open Reduction, Simple
Procedure 903	Mandible - Closed Reduction, Simple
Procedure 904	Maxilla - Closed Reduction, Compound
Procedure 905	Maxilla - Open Reduction, Compound
Procedure 906	Mandible - Closed Reduction, Compound
Procedure 907	Mandible - Open Reduction, Compound
Procedure 913	Reduction of Dislocation of Temporomandibular Joint
Procedure 915	Treatment of Malar Fracture, Simple, Closed Reduction
Procedure 916	Treatment of Malar Fracture, Simple or Compound Depressed, Open Reduction
Procedure 960	Speech appliance, transitional, with or without pharyngeal extension
Procedure 962	Speech appliance, permanent, edentulous, with or without pharyngeal extension
Procedure 964	Speech appliance, permanent, partially edentulous, cast framework, with or without pharyngeal extension
Procedure 966	Palatal lift, interim
Procedure 968	Palatal lift, permanent cast framework
Procedure 970	Obturator, immediate surgical, routine
Procedure 971	Obturator, immediate surgical, complex
Procedure 972	Obturator, permanent, complex
Procedure 973	Resection prosthesis, permanent, edentulous, complex
Procedure 974	Resection prosthesis, permanent, edentulous, routine
Procedure 975	Resection prosthesis, permanent, partially edentulous, complex
Procedure 976	Repositioner, mandibular, two piece
Procedure 977	Removable facial prosthesis
Procedure 978	Splints and stents
Procedure 979	Radiation therapy fluoride carrier
Procedure 980	Repairs, maxillofacial prosthesis
Procedure 981	Rebase, laboratory processed maxillofacial prosthesis
Procedure 982	Balancing (opposing) maxillofacial appliance
Procedure 985	Maxillofacial surgical procedures
Procedure 998	Unlisted therapeutic service
Procedure 999	Unlisted procedures

Emergency Services

As a reminder, an emergency dental condition is a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, which in the absence of immediate dental attention could reasonably be expected to result in any of the following: placing the patient's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. The emergency must be certified by the dental provider in accordance with Section 51056 of Title 22, California Code of Regulations. The California Department of Health Services may review the provider's decision that an emergency existed and that the services were medically necessary.

The following procedure codes may also be exempt from the limitation if they are related to an adequately documented emergency service.

Denti-Cal Procedure Codes for Emergency Services	
Procedure 020	Office Visit During Regular Office Hours, for Treatment and/or Observation of Teeth or Supporting Structures
Procedure 030	Professional Visit After Regular Office Hours or to Bedside
Procedure 035	Hospital Care
Procedure 040	Specialist Consultation
Procedure 080	Emergency Treatment, Palliative
Procedure 110	Intraoral Periapical, Single, First Radiograph
Procedure 111	Intraoral Periapical, Each Additional Radiograph
Procedure 113	Intraoral, Occlusal Radiograph
Procedure 114	Extraoral, Single, Head or Lateral Jaw
Procedure 115	Extraoral, Each Additional Head or Lateral Jaw
Procedure 116	Bitewings, Two Radiographs
Procedure 117	Bitewings, Four Radiographs
Procedure 118	Bitewings, Anterior, One Radiograph
Procedure 125	Panographic Film, Single Radiograph
Procedure 200	Removal of Erupted Tooth, Uncomplicated, First Tooth
Procedure 201	Removal of Erupted Tooth (Teeth), Uncomplicated, Each Additional Tooth
Procedure 202	Removal of Erupted Tooth, Surgical
Procedure 203	Removal of Root or Root Tip Completely Covered by Bone
Procedure 204	Removal of Root or Root Tip Not Totally Covered by Bone
Procedure 220	Postoperative Visit, Complications, e.g., Osteitis
Procedure 230	Removal of Impacted Tooth, Soft Tissue
Procedure 231	Removal of Impacted Tooth, Partial Bony
Procedure 232	Removal of Impacted Tooth, Complete Bony
Procedure 259	Excision of Hyperplastic Tissue, Per Arch
Procedure 262	Excision Pericoronal Gingiva (Operculectomy)
Procedure 290	Excision of Foreign Body, Soft Tissue
Procedure 300	Therapeutic Drug Injection
Procedure 301	Conscious Sedation, Relative Analgesia (Nitrous Oxide), Per Visit

Denti-Cal Procedure Codes for Emergency Services	
Procedure 400	General Anesthesia
Procedure 451	Emergency Treatment (Periodontal Abscess, Acute Periodontitis, etc.)
Procedure 501	Therapeutic Pulpotomy
Procedure 502	Vital Pulpotomy
Procedure 503	Recalcification, Includes Temporary Restoration, Per Tooth
Procedure 750	Repair Broken Denture Base Only (Complete or Partial)
Procedure 754	Each Additional Denture Tooth Replaced on 753 Repair (Maximum Two)
Procedure 755	Adding First Tooth to Partial Denture to Replace Newly Extracted Natural Tooth
Procedure 751	Repair Broken Denture Base and Replace One Broken Denture Tooth (Maximum Two)
Procedure 752	Each Additional Denture Tooth Replaced on 751 Repair (Maximum Two)
Procedure 753	Replace One Broken Denture Tooth Only (Complete or Partial)
Procedure 756	Each Additional Natural Tooth Replaced on 755 Repair (Maximum Two)
Procedure 757	Add a New or Replace Broken Chrome Cobalt Assembled Wrought Clasp with Two Clasp Arms and Rest to an Existing 702 Partial Denture
Procedure 758	Each Additional New or Replacement Clasp for Repair 757 (Maximum Two)
Procedure 759	Add a New or Replace Broken Chrome Cobalt Assembled Wrought Clasp with Two Clasp Arms and No Rest to an Existing 708 Partial Denture
Procedure 760	Each Additional New or Replacement Clasp for Repair 759 (Maximum Two)
Procedure 761	Reattaching Clasp on Partial Denture, Clasp Intact, Each (Maximum Two)
Procedure 762	Add a New Clasp or Replace a Broken Cast Chrome Cobalt Clasp With Two Clasp Arms and Rest to an Existing 703 Partial Denture
Procedure 763	Each Additional New or Replacement Clasp for Repair 762 (Maximum Two)

All other procedure codes will be subject to the $1,800 calendar year limitation. If the annual cap has been met and nothing has been paid on a procedure, providers are allowed to bill beneficiaries their usual, customary and reasonable fees.

For questions regarding any of the above, please contact Denti-Cal toll-free at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 22, NUMBER 27 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 SEPTEMBER 2006

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

National Provider Identifier (NPI) Update

Only 8 months until the NPI compliance date!
Do you have your NPI?

Denti-Cal providers, dental plans, and clearinghouses *must* begin submitting the NPI on all HIPAA electronic covered transactions beginning May 23, 2007.

Providers must continue utilizing their existing Denti-Cal provider numbers until further notice.

Providers may apply for an NPI in one of three ways:

- ✓ Visiting the Web site at http://nppes.cms.hhs.gov;
- ✓ Mailing a completed paper application to the address found at the above Web site;
- ✓ Calling (800) 465-3203 or (800) 692-2326 (TTY).

For more general information about the NPI, please visit the Web site for the Centers for Medicare & Medicaid Services (CMS) at http://www.cms.hhs.gov/NationalProvIdentStand and for frequently asked questions:

http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=bI-syZ8i

Current Dental Terminology (CDT)

CDT code and criteria implementation is targeted for mid-to-late 2007, pending final regulatory approval.

CDT codes will not be accepted by Denti-Cal at this time. Any claim service line (CSL) submitted with a CDT procedure code, an invalid procedure code, or a blank procedure code field will be denied.

If there are any questions, please call Denti-Cal toll-free at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 22, NUMBER 28 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 SEPTEMBER 2006

CERTAIN DENTI-CAL FORMS NO LONGER ACCEPTED

Due to changes in technology, the following claim and Treatment Authorization Request (TAR) forms are not available: DC-001A, DC-001B, DC-001C, DC-001D. The U.S. Postal Service instructed Denti-Cal to no longer use these forms because the imprinted addresses on the attached envelopes cannot be read by their automated equipment.

Effective January 1, 2007, the above-mentioned forms will no longer be accepted and will be returned without processing. Please ensure your office has sufficient quantity of the following alternative forms:

- DC-002A, No Carbon Required (NCR) Claim; and DC-002B, NCR TAR
- DC-009A, Continuous Claim; and DC-009B, Continuous TAR
- DC-017A, Laser Claim; and DC-017B, Laser TAR

Also, be sure to have enough envelopes. The three listed in the first group below are for mailing required documentation to Denti-Cal. The four listed in the second group are to be used only for X-rays.

Envelopes for mailing claims and TARs to Denti-Cal are:

- DC-006A, Large Envelope to Mail Claims
- DC-006B, Large Envelope to Mail TARs
- DC-007, #10 Envelope for Correspondence

Envelopes specifically used for X-rays are:

- DC-014A, Large Envelope to send X-rays with Claims
- DC-014B, Large Envelope to Send X-rays with TARs
- DC-014C, Small Envelope to Send X-rays with Claims
- DC-014D, Small Envelope to Send X-rays with TARs

If there are any questions, please call Denti-Cal toll-free at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 22, NUMBER 29 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 SEPTEMBER 2006

NO CLAIM ACTIVITY FOR 12 MONTHS

Providers who have had no claim activity (submitting no claims or requesting reimbursement) in a 12-month period shall be deactivated per Welfare and Institutions Code Section 14043.62 which reads as follows:

> *The department shall deactivate, immediately and without prior notice, the provider numbers used by a provider to obtain reimbursement from the Medi-Cal program when warrants or documents mailed to a provider's mailing address or its pay to address, if any, or its service or business address, are returned by the United States Postal Service as not deliverable or when a provider has not submitted a claim for reimbursement from the Medi-Cal program for one year. Prior to taking this action the department shall use due diligence in attempting to contact the provider at its last known telephone number and ascertain if the return by the United States Postal Service is by mistake or shall use due diligence in attempting to contact the provider by telephone or in writing to ascertain whether the provider wishes to continue to participate in the Medi-Cal program. If deactivation pursuant to this section occurs, the provider shall meet the requirements for reapplication as specified in this article or the regulations adopted hereunder.*

If you have not had any claim activity in a 12-month period, and wish to remain an active provider in the Medi-Cal Dental Program, please complete the bottom portion of this form and mail to: Medi-Cal Dental Program, P.O. Box 15609, Sacramento, CA 95852-0609. If your provider number is deactivated, you must reapply for enrollment in the Medi-Cal Dental Program. To request an enrollment package contact Denti-Cal toll-free at (800) 423-0507.

Yes, I wish to remain a provider in the California Medi-Cal Dental Program because _____

_____

Check the boxes that apply to your practice:

- ☐ AHK (Alameda Healthy Kids)
- ☐ CCS (California Children's Services)
- ☐ DMC (Dental Managed Care) Plan Name: _____
- ☐ FQHC/RHC (Federally Qualified Health Clinic/Rural Health Clinic)
- ☐ GHPP (Genetically Handicapped Persons Program)
- ☐ GMC (Geographic Managed Care) Plan Name: _____
- ☐ HFP (Healthy Families Program)

_____ _____ _____

Provider Name Provider Number Provider Signature

_____

Provider Address City Zip Code

If your office has relocated, a new enrollment package must be submitted. Please check the box indicating your type of practice and Denti-Cal will send the necessary forms for completion:

- ☐ Group
- ☐ Individual

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 22, NUMBER 30 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 OCTOBER 2006

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

National Provider Identifier (NPI) Update

Only 7 months until the NPI compliance date!
Do you have your NPI?

What is the NPI?

The NPI is a 10-digit number that will be used to identify you to your health care partners. The NPI is replacing all provider numbers including your Denti-Cal billing and rendering provider numbers currently used today.

There are two entity types that are recognized by the National Provider Identifier Enumerator:

- Entity Type 1: Health care providers who are individual human beings, including dentists and hygienists.
- Entity Type 2: Health care providers who are organizations, including dental practices, and/or individual dental practices who are incorporated.

Who will need an NPI?

Effective May 23, 2007, Denti-Cal providers must obtain, register, and use an NPI if:

- The Provider submits claims electronically and verifies eligibility via the Point of Service (POS) Device or the Internet
- The Provider submits paper claims and verifies eligibility via the Point of Service (POS) Device or the Internet
- A new provider is enrolling for the first time into the Denti-Cal program

Note: Rendering providers must obtain an NPI if they work for a billing provider who submits claims electronically.

Subparting

The Federal Register, 45 CFR, Part 162, NPI Final Rule, refers to separate physical locations as "subparts" of an organizational health care provider. Providers, who receive one NPI rather than subpart, may experience delays in the return of payments, Explanation of Benefits (EOBs), Request Turnaround Documents (RTDs), and Notice of Authorizations (NOAs). Therefore, Denti-Cal encourages qualifying providers to subpart.

Please contact the National Provider Identifier Enumerator for more information on subparting.

Electronic Claim Submission

In conjunction with the deadline to accept an NPI, providers who submit claims electronically will need to use the 4010A1 version of the 837 claim transaction by May 23, 2007. Denti-Cal has been assisting clearinghouses and practice management vendors in converting to the new claim format. For more information on conversion to the 4010A1 format, please call your software vendor, clearinghouse or Denti-Cal's Telephone Service Center at (800) 423-0507 and ask for EDI Support.

How to obtain an NPI

Providers may obtain an NPI using the resources listed below:

Phone the National Provider Identifier Enumerator Call Center at:
1-800-465-3203
1-800-692-2326 (TTY)

To request that an application be mailed, please write to:
NPI Enumerator
P.O. Box 6059
Fargo, ND 58108-6059

To complete the on-line application or for information on the NPI final rule, please visit:
https://nppes.cms.hhs.gov

For help or questions, e-mail the National Provider Identifier Enumerator Customer Service at:
customerservice@npienumerator.com

For additional information about NPI, please visit http://nppes.cms.hhs.gov.

NPI Registration

Denti-Cal providers will be required to register their NPI with Denti-Cal. More information will be provided in upcoming bulletins detailing how and when to register your NPI with Denti-Cal.

Enrolled providers must continue to use their current Denti-Cal provider number until May 23, 2007.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 22, NUMBER 31 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 OCTOBER 2006

CORRECT USE OF DENTI-CAL ENVELOPES

Denti-Cal offers special mailing envelopes for enclosing X-rays with claims, TARs, and EDI X-rays. Denti-Cal's mailing envelopes have borders printed in various colors to indicate the type of documents enclosed, which aids in sorting and expedites processing. Please refer to the Denti-Cal Provider Manual for additional information on Electronic Data Interchange (EDI) (Section 2) or Denti-Cal forms and envelope inventory (Section 3).

The following guide will assist you in determining which envelope should be used:

- Please do not paper clip, staple, or tape X-rays to TARs or claims as this may delay processing and payment for services rendered. Following these procedures will ensure that X-rays are not separated from the documents and can be promptly returned to your office or recycled by Denti-Cal.
- Enclose mounted, dated, and well marked X-rays in the appropriate X-ray envelope. Be sure to include the dentist's name, Denti-Cal provider number, and patient name and Medi-Cal ID number. Duplicate X-rays and paper radiographs should also be marked clearly so they are identifiable for speedy processing. The date on paper radiographs must be in month/date/year format.
- *Use one envelope per beneficiary. Do not place X-rays for multiple beneficiaries into a single envelope as this creates delays, and could result in incorrect matching of the X-rays to companion documents.*
- *Only use X-ray envelopes for X-rays or paper radiographs. All other attachments and documentation should be stapled to the claim or TAR to reduce processing delays. Do not overfill X-ray envelopes. The appropriately sized envelopes should be used for all X-rays submitted to prevent damaged envelopes and/or lost X-rays.*
- Up to three unmounted X-rays may be submitted by placing them in unsealed coin-size envelopes and inserting the coin-size envelopes into the X-ray envelopes provided by Denti-Cal.
- Remember to attach all X-ray envelopes to the corresponding claim or TAR form before placing them into a mailing envelope and sending to Denti-Cal. Be sure to check each X-ray envelope carefully to make sure the glue on the sides of the envelope is intact before enclosing your X-rays. Please discard any questionable envelopes.
- Much time and manpower is expended returning duplicate X-rays and paper radiographs to the provider. If they must be returned, please place a "Do Not Recycle" sticker on the outside of the X-ray envelope next to your return address. To obtain these stickers, please call Denti-Cal toll-free at (800) 423-0507.

GREEN (DC-006A) envelopes should only contain:

- Claims
- Claim Inquiry Forms (CIFs)
- Resubmission Turnaround Documents (RTDs) relating to Claims
- Notice of Authorization (NOA) forms submitted for payment
- Electronic Data Interchange (EDI) NOAs printed onto paper for payment (do not attach EDI label)
- EDI RTDs printed onto paper related to claims (do not attach EDI label)
- Preimprinted X-ray envelopes (DC-014A and DC-014C)

BLUE (DC-006B) envelopes should only contain:

- Treatment Authorization Requests (TARs)
- RTDs relating to TARs
- EDI NOAs printed onto paper for reevaluation (do not attach EDI label)
- EDI RTDs printed onto paper related to TARs (do not attach EDI label)
- Claim Inquiry Forms (CIFs) for TAR tracers only
- Preimprinted X-ray envelopes (DC-014B and DC-014D)

RED (DC-006C) envelopes should only contain:

- Attachments and back-up documentation to support authorized treatment
- X-ray envelopes DC-014E and DC-014F (these are not preimprinted; please order accompanying DC-018A mailing labels)

AS A REMINDER, *all* forms, envelopes, labels, and stickers are free of charge.

To order additional supplies of these envelopes and labels, either fax: the Denti-Cal Forms Reorder Request (DC-004) or EDI Supply Request Form (Denti-Cal 139) to the Denti-Cal forms vendor at (209) 832-2105 or mail said forms to:

Shamrock Companies, Inc.
410 East. Grantline Road
Tracy, CA 95376

If there are any questions, please call Denti-Cal toll-free at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 22, NUMBER 32 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 NOVEMBER/DECEMBER 2006

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

National Provider Identifier (NPI) Update

Only 6 months until the NPI compliance date!
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Fargo, ND 58108-6059

To complete the on-line application or for information on the NPI final rule, please visit:
https://nppes.cms.hhs.gov

For help or questions, e-mail the National Provider Identifier Enumerator Customer Service at:
customerservice@npienumerator.com

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California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 22, NUMBER 33 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 NOVEMBER/DECEMBER 2006

SEMINAR SCHEDULE FOR FIRST QUARTER 2007

Basic Seminars

- Introduction to California Medi-Cal Dental Program
- Enrollment and Eligibility
- Proper Billing Procedures
- The Roseville and San Bernardino seminars have been expanded to include an overview of Electronic Data Interchange (EDI)

Workshops

- Enrollment and Eligibility
- Criteria and Current Changes
- Hands-On Forms Completion
- HIPAA Informational Updates

Advanced Seminars

- Criteria Presented *by* a Dentist *for* Dentists and Staff
- View Actual Treatment Slides

ABOUT THE SEMINARS AND WORKSHOPS

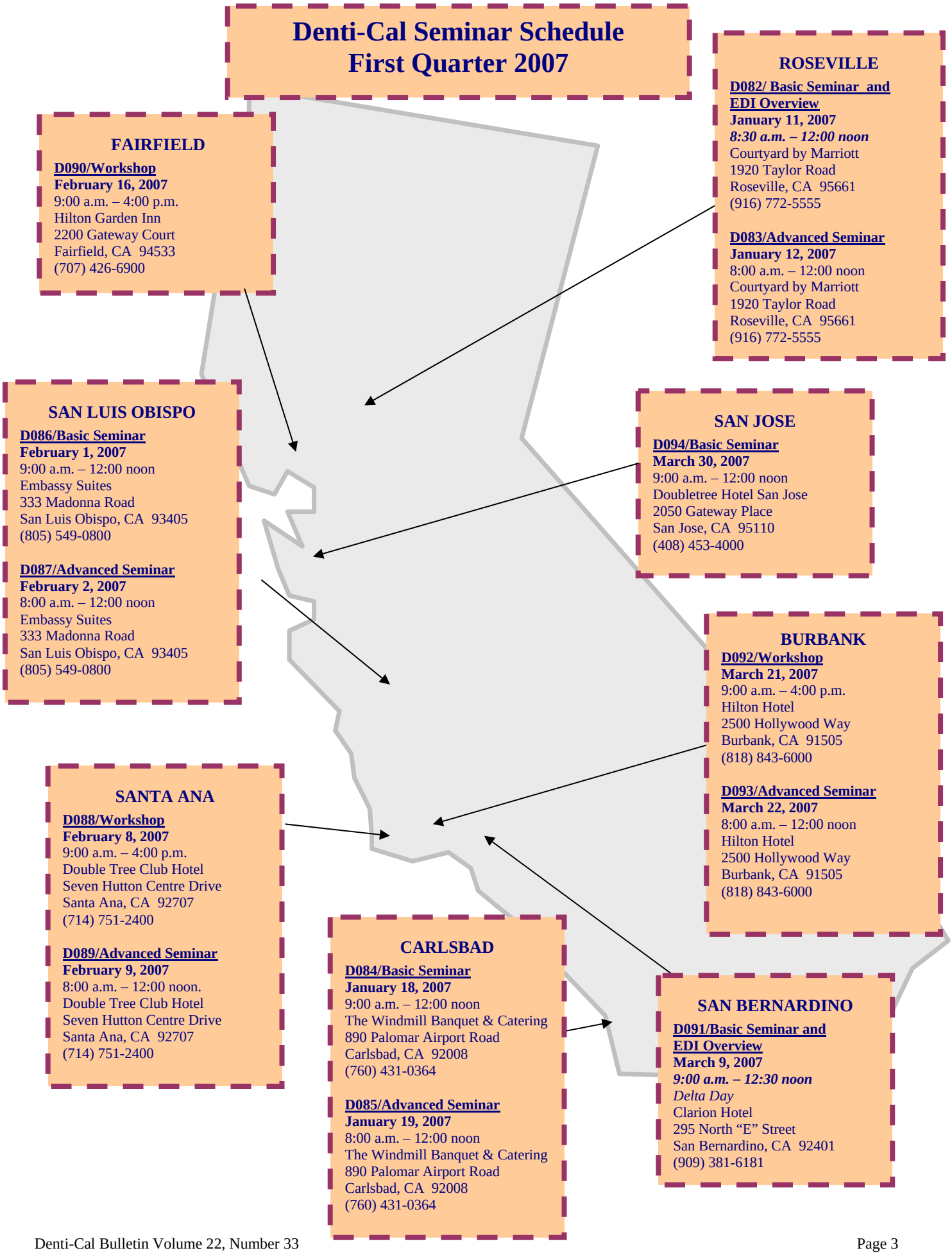
- Seminars and workshops are offered *free of charge*.
- Sessions begin *on time*, so arrive early.
- Bring your updated *Denti-Cal Provider Manual* to get the most from the training.
- Audio/video recording is not allowed.
- Billing information is subject to change.
- Reservations ensure that a space is available for you! Likewise, please let us know if you are unable to attend.
- Continuing education credits are available:

Basic Seminars	3 CE credits
Advanced Seminars	4 CE credits
Workshops	6 CE credits

- Some facilities may charge for parking.
- The use of cell phones during the seminar is strongly discouraged. If you must be available for calls, please be courteous and set the ringer on vibrate.

For additional information, questions and to register, please phone Denti-Cal toll-free at (800) 423-0507.

Denti-Cal Seminar Schedule
First Quarter 2007



ROSEVILLE

D082/ Basic Seminar and EDI Overview
January 11, 2007
8:30 a.m. – 12:00 noon
Courtyard by Marriott
1920 Taylor Road
Roseville, CA 95661
(916) 772-5555

D083/Advanced Seminar
January 12, 2007
8:00 a.m. – 12:00 noon
Courtyard by Marriott
1920 Taylor Road
Roseville, CA 95661
(916) 772-5555

FAIRFIELD

D090/Workshop
February 16, 2007
9:00 a.m. – 4:00 p.m.
Hilton Garden Inn
2200 Gateway Court
Fairfield, CA 94533
(707) 426-6900

SAN LUIS OBISPO

D086/Basic Seminar
February 1, 2007
9:00 a.m. – 12:00 noon
Embassy Suites
333 Madonna Road
San Luis Obispo, CA 93405
(805) 549-0800

D087/Advanced Seminar
February 2, 2007
8:00 a.m. – 12:00 noon
Embassy Suites
333 Madonna Road
San Luis Obispo, CA 93405
(805) 549-0800

SAN JOSE

D094/Basic Seminar
March 30, 2007
9:00 a.m. – 12:00 noon
Doubletree Hotel San Jose
2050 Gateway Place
San Jose, CA 95110
(408) 453-4000

BURBANK

D092/Workshop
March 21, 2007
9:00 a.m. – 4:00 p.m.
Hilton Hotel
2500 Hollywood Way
Burbank, CA 91505
(818) 843-6000

D093/Advanced Seminar
March 22, 2007
8:00 a.m. – 12:00 noon
Hilton Hotel
2500 Hollywood Way
Burbank, CA 91505
(818) 843-6000

SANTA ANA

D088/Workshop
February 8, 2007
9:00 a.m. – 4:00 p.m.
Double Tree Club Hotel
Seven Hutton Centre Drive
Santa Ana, CA 92707
(714) 751-2400

D089/Advanced Seminar
February 9, 2007
8:00 a.m. – 12:00 noon.
Double Tree Club Hotel
Seven Hutton Centre Drive
Santa Ana, CA 92707
(714) 751-2400

CARLSBAD

D084/Basic Seminar
January 18, 2007
9:00 a.m. – 12:00 noon
The Windmill Banquet & Catering
890 Palomar Airport Road
Carlsbad, CA 92008
(760) 431-0364

D085/Advanced Seminar
January 19, 2007
8:00 a.m. – 12:00 noon
The Windmill Banquet & Catering
890 Palomar Airport Road
Carlsbad, CA 92008
(760) 431-0364

SAN BERNARDINO

D091/Basic Seminar and EDI Overview
March 9, 2007
9:00 a.m. – 12:30 noon
Delta Day
Clarion Hotel
295 North "E" Street
San Bernardino, CA 92401
(909) 381-6181

DENTI-CAL PROVIDER TRAINING SEMINAR RESERVATION FORM

TYPE OF SEMINAR:

☐ Basic Seminar
(Seminar Code Number:_____)

☐ Workshop
(Seminar Code Number:_____)

☐ Advanced Seminar
(Seminar Code Number:_____)

Seating for all seminars is limited, so reserve your place today by returning this reservation form in the enclosed envelope to Denti-Cal. Be sure to include the seminar code number and indicate the names of staff who will be attending. Denti-Cal is unable to confirm your reservation by mail, so be sure to note the date and time on your calendar. ***To help us keep administrative costs down and continue to offer you free educational seminars, we request that you notify Denti-Cal toll-free at (800) 423-0507 in the event you need to cancel your reservation.***

PLEASE TYPE OR PRINT CLEARLY

Yes, I/my office staff wish to attend the Denti-Cal provider training seminar(s) indicated above. The name(s) of the person(s) attending are:

1._____ 4._____

2._____ 5._____

3._____ 6._____

In the area below, please type or print the dentist's name and office address:

_____ Provider No.:_____

_____

_____ Phone No.:_____

_____

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 22, NUMBER 34 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 NOVEMBER/DECEMBER 2006

FREQUENTLY ASKED QUESTIONS (FAQs) ON THE EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) SERVICES AVAILABLE THROUGH THE MEDI-CAL DENTAL (DENTI-CAL) PROGRAM

What is EPSDT?

The early and periodic screening, diagnosis, and treatment (EPSDT) program is a special process within Denti-Cal specifically for children. Under federal law, EPSDT services are provided to any Medicaid beneficiary under age 21. For the Denti-Cal Program, this means medically necessary dental services provided for any Medi-Cal dental beneficiary who has not yet reached his or her 21st birthday are EPSDT services.

What kind of dental services are classified as EPSDT?

Whenever a Denti-Cal provider completes an oral examination on a child, an EPSDT screening service (and diagnostic service) has occurred. Any subsequent dental treatment resulting from that examination is considered an EPSDT dental service ***if*** the dental procedure is published in the Denti-Cal Manual of Criteria (see Section 4 of the *Denti-Cal Provider Manual*).

What is an EPSDT Supplemental Service?

Denti-Cal children may need dental services that are not part of the scope of benefits found within the Manual of Criteria (found in Section 4 of the *Denti-Cal Provider Manual*). Denti-Cal covers these services, too. In California, these services are called EPSDT Supplemental Services or "EPSDT-SS."

Example 1: John S. has a craniofacial anomaly with multiple edentulous areas. The edentulous areas cannot be adequately restored using conventional prosthetics – an implant-retained fixed prosthesis may be authorized as EPSDT Supplemental Services.

EPSDT-SS also covers situations when the dental service being requested may be listed in the Manual of Criteria, but the child does not meet the published criteria.

Example 2: Cindy T. (age 13) suffers from aggressive periodontitis and requires periodontal scaling and root planing. The Manual of Criteria, however, states this procedure is not a benefit for patients under 18 years of age. The medically necessary periodontal procedures may be authorized as EPSDT Supplemental Services.

FREQUENTLY ASKED QUESTIONS (FAQs) ON THE EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) SERVICES AVAILABLE THROUGH THE MEDI-CAL DENTAL (DENTI-CAL) PROGRAM

What is an EPSDT Supplemental Service (continued)?

Example 3: Alicia M. (age 15) has fractured an anterior tooth in an accident. Although only three surfaces were involved in the traumatic destruction, the extent is such that a bonded restoration will not be retentive. With adequate supplemental documentation (in this case, intraoral photographs of the fractured tooth) and narrative explanation by the dentist, a prefabricated or laboratory-processed crown may be authorized as an EPSDT Supplemental Service.

Example 4: Andre W. does not qualify for orthodontic services per the handicapping malocclusion criteria (he scores below 26 points on the HLD Index or does not have one of the five automatic qualifying conditions). However, a speech pathologist has determined that his malocclusion is a prime etiologic factor in his speech pathosis – resolution cannot be achieved unless his malocclusion is corrected. In this case, orthodontics may be authorized as an EPSDT Supplemental Service.

When would I request an EPSDT Supplemental Service for my child patients?

You would request prior authorization for an EPSDT Supplemental Service under any one of the following conditions:

1) To perform a medically necessary dental procedure that is not listed in the current Manual of Criteria.
2) To perform a medically necessary dental procedure that is listed in the current Manual of Criteria when the child does not meet the published criteria.
3) The child needs a dental service more frequently than is currently allowed under Program criteria.

How do I request an EPSDT Supplemental Service?

All EPSDT Supplemental Services must be prior authorized and you MUST print "**EPSDT Supplemental Services Request**" in Field 34 of the Treatment Authorization Request (TAR) form. If the requested dental service is not listed within the Manual of Criteria, use Procedure Code 999 and fully describe the service (in addition, please include the applicable CDT code for that service within the description, but do not place in Field 31). Do not limit your comments to Field 34 of the TAR form – attach all documents to the TAR that are needed to describe the requested services.

FREQUENTLY ASKED QUESTIONS (FAQs) ON THE EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) SERVICES AVAILABLE THROUGH THE MEDI-CAL DENTAL (DENTI-CAL) PROGRAM

What kind of clinical information does the Program need to determine the medical necessity?

At a minimum, you should address the following:

- Diagnosis of the dental condition
- Any overall health issues and medical conditions
- Prognosis with and without the requested treatment
- Clinical rationale for why a covered benefit or lower-cost service will not suffice (you are encouraged to include copies of published clinical studies or articles from peer-reviewed, professional dental journals to support your rationale).

Note: Documentation can be narrative, radiographic, photographic, or copies of any relevant documents (including diagnostic imaging).

In some cases, the dental services are necessary to resolve or improve an associated medical condition. For example, a child's speech therapist determines that a diagnosed speech pathosis cannot be resolved without dental treatment. A consultation letter from the speech therapist should be included with the EPSDT Supplemental Services TAR.

It is virtually impossible to submit too much documentation with your TAR for EPSDT Supplemental Services!

Whom can I call to obtain further information about the EPSDT and EPSDT-SS requirements under Denti-Cal?

Denti-Cal Telephone Service Center Representatives are available via the Provider Toll-Free Phone Line (800/423-0507) to answer all of your questions regarding EPSDT services and EPSDT Supplemental Services.